County of Los Angeles - Department of Mental Health
Housing and Job Development Division
Federal Housing Subsidies Unit

LACDA CONTINUUM OF CARE (CoC) APPLICATION COVERSHEET & CHECKLIST - (Rev. 10/22/24)

Client Name:_____ SS#:_____
Name of Agency: DMH /_____ DMH Provider #: _____
DMH/ICMS Case Manager:_____ Service Area: _____ Supr. District _____
DMH/ICMS Case Manager Email:_____ Case Manager Phone #:_____

The following forms are required for every applicant under the CoC Program. In order for the Los Angeles County Development Authority (LACDA), a.k.a. Housing Authority, to expedite the process of reviewing and approving your referrals, please complete all forms thoroughly. Place a check mark next to those documents included in this application packet and arrange forms in the following order:

_____ 1. LACDA CoC Application Coversheet and Checklist (DMH form)
_____ 2. LACDA Program Transmittal/Referral Form – Continuum of Care
_____ 3. CES Referral Form, completed by the LAHSA Countywide CES Matcher only
_____ 4. LACDA Special Programs Application for Rental Assistance, 11 pgs. (This form is not on the web, contact FHSU)
_____ 5. LACDA Non-Discrimination Policy
_____ 6. LACDA Authorization for Release of Information (to verify application), 2 pgs.
_____ 7. Supplement to Application for Federally Assisted Housing – DMH Service Provider
_____ 8. Supplement to Application for Federally Assisted Housing – DMH / HJDD
_____ 9. Free Language Services
_____ 10. LACDA Citizenship Declaration, 3 pgs. (Signed by all household members)
_____ 11. LACDA Consent Form to Verify Immigration Status with the U.S. Citizenship and Immigration Services, 1 pg.
_____ 12. LACDA Authorization for Release of Confidential Department of Public Social Services Information, 1 pg.
_____ 13. Certification of No Conflict of Interest (LACDA form signed by client and case manager)
_____ 14. DMH HJDD Housing Intake and Needs Assessment, 3 pgs.
_____ 15. LACDA CoC Housing Intake Assessment, 1 pg.
_____ 16. Continuum of Care Service Provider Responsibility Form, 2 pgs. (DMH form)
_____ 17. Continuum of Care Program Participant Agreement (DMH form signed by both client and case manager)
_____ 18. LACDA Continuum of Care Program Application Checklist
_____ 19. Verification of Assets/Bank Statements (Include all pages; cannot be more than 60 days old)
_____ 20. Identification Documents
___ Copy of CA ID/DL for **each** adult household member
___ Copy of Social Security Card for **all** household members
___ Copy of Birth Certificate for **all** minors in the household
_____ 21. DedicatedPLUS Packet
_____ Form 2835 – DedicatedPLUS Verification Packet/Part A: Cover Checklist, 3 pgs.
_____ Form 6053: Homelessness Verification Form, 2 pgs.
_____ Form 1446: Agency Due Diligence to Acquire 3rd Party Homelessness Verification, 1 pg.
_____ HMIS Printout (insert)
_____ Form 2833: Verification of Disability, 2 pgs.
_____ 22. MH 677 Authorization for Use/Disclosure of PHI (DMH to LACDA), 2 pgs. (DMH form)
_____ 23. Authorization to Release (LACDA to DMH), 1 pg.
_____ 24. Clarity HMIS Intake and Enrollment Packet (LAHSA form) to be completed for **each adult and minor** in the household
_____ LA HMIS Consent to Share Protected Personal Information, 3 pgs.
_____ HMIS Intake and Enrollment Form, 19 pgs.
_____ 25. MH 677 Authorization for Use/Disclosure of PHI (DMH to HMIS), 2 pgs. (DMH form)
_____ 26. Affordable Care Act Certification Form (DMH form)
_____ 27. McKinney Vento Act Notice – Acknowledgment of Receipt (DMH form)
_____ 28. Agency Referral Letter (On current letterhead, include a 3-year timeline of housing / homelessness history and explanation of address on ID if different from current address & why client can't return there.)

HOUSING COMMUNITY ECONOMIC
LACDA
Los Angeles County Development Authority

MAIN OFFICE
700 W. Main Street, Alhambra, CA 91801
Tel: 626-262-4510 TDD: 626-943-3898
www.lacda.org

HOUSING ASSISTANCE DIVISION
SITE: ANTELOPE VALLEY OFFICE - 2323 E. Palmdale Blvd., Suite B, Palmdale, CA 93550 Tel: 661-575-1511

Los Angeles County Development Authority
Program Transmittal/Referral Form
CONTINUUM OF CARE

To: Los Angeles County Development Authority
700 W. Main Street, Alhambra, CA 91801

From: DMH / HJDD /

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

Client Name: _____

SSN: _____ DOB: _____

Agency Address: DMH / HJDD / 510 S. Vermont Ave., 17th Fl

City, State, Zip: Los Angeles, CA 90020

Agency Telephone Number: _____

Referral Grant Number (Continuum of Care Only): _____

Date referral submitted for approval to the LACDA: _____

_____ _____
Agency Contact Signature Client Signature

_____ _____
Date Date

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

Affix agency stamp or business card:

TO OBTAIN A CES REFERRAL FORM:

- Send an email to the LAHSA Countywide Tenant-Based Resource Matcher and provide the following information:
  - Purpose of email/request
    - It is highly recommended that the subject line of your email should be “Request for CES Referral Form”
  - Client’s HMIS ID#

The email address for the LAHSA Countywide Tenant-Based Resource Matcher is:

CESMatching@lahsa.org

PLACE HERE

HOUSING AUTHORITY SPECIAL PROGRAMS APPLICATION FOR RENTAL ASSISTANCE (11pgs)

To get a copy of this form, please refer to the email you received from the DMH/Federal Housing Subsidies Unit (FHSU) staff indicating that your client was approved to complete a housing application.

For any questions, you may contact:

FHSU@dmh.lacounty.gov

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Non-Discrimination Policy

It is the policy of the Los Angeles County Development Authority (LACDA) to comply with the Fair Housing Act, Title VIII of the Civil Rights Act of 1968, as amended by the Fair Housing Amendments Act of 1988, 42 U.S.C. §§ 3601 *et seq*., by ensuring that housing is available to all persons without regard to race, color, religion, national origin, disability, familial status (having children under age 18), or sex. This policy means that, among other things, LACDA and its agents or employees must not discriminate in any aspect of housing including, but not limited to, denying persons access to housing, because of race, color, religion, national origin, disability, familial status, or sex. Such agents and employees may not:

a. Make unavailable or deny a dwelling to any person because of race, color, religion, national origin, disability, familial status, or sex;

b. Discriminate against any person in the terms, conditions, or privileges of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, national origin, disability, familial status, or sex;

c. Make, print, or publish, or cause to be made, printed, or published any notice, statement, or advertisement, with respect to a dwelling that indicates any preference, limitation, or discrimination based on race, color, religion, national origin, disability, familial status, or sex, or an intention to make any such preference, limitation, or discrimination; or

d. Coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other person in the exercise or enjoyment of, any right granted or protected by the Fair Housing Act.

Any agent or employee who fails to comply with this non-discrimination policy will be subject to appropriate disciplinary action. Any action taken by an agent or employee that results in the unequal treatment of citizens on the basis of race, color, religion, national origin, disability, familial status, or sex, may constitute a violation of state and federal fair housing laws. An individual who believes that he or she is the victim of discrimination may contact the U.S. Department of Housing and Urban Development at 1-800-669-9777, or the U.S. Department of Justice at 1-800-896-7743.

LOS ANGELES COUNTY DEVELOPMENT AUTHORITY
HOUSING ASSISTANCE DIVISION
700 W. Main Street, Alhambra, CA 91801

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersign(s) do hereby authorize any agency, office, group, organization, business firm, financial institution, public or private school, or governmental entity, to release to the Los Angeles County Development Authority (LACDA), any information or materials which LACDA deems necessary to complete and verify my application for participation and/or to maintain my continued assistance under the Section 8 Certificate Program, Housing Voucher Program, Low Income Housing Programs, or any other program that LACDA may administer.

The information needed may include, but is not limited to: verification or inquiries regarding my identity, household members (including minors in my household), employment, income, financial accounts, assets, school records, allowances or preferences I have claimed, and residency.

The entities which LACDA may request release of information shall include, but are not limited to: financial institutions (42 U.S.C. Sec 3544); social service agencies; educational institutions; welfare agencies; Veteran's Administration; court clerks; utility companies; workmen's compensation payers; public and private retirement systems; law enforcement agencies; credit providers; postal service; and unemployment insurance agencies.

Records from financial institutions shall include all credit card account statements, loan account statements, mortgage account statements, loan applications, credit applications and any and all other account statements.

It is understood and agreed that this authorization or the information obtained with its use may be given to and used by LACDA in the administration and enforcement of program rules and regulations and that LACDA may in the course of its duties obtain such information from other Federal, State, or local agencies including State Employment Security Agencies; Department of Defense; Office of Personnel Management; the Social Security Administration; and welfare and food stamp agencies.

It is with my understanding and consent that a photocopy of this authorization may be used for the purposes stated above. This authorization for release of information expires fifteen months after the date signed.

AUTHORIZATION FOR RELEASE OF INFORMATION (Page 2 of 2)

(This consent form expires 15 months after signed.)

Instructions: Provide head of household's name, social security number, address, phone number and birth date, and name, birth date and social security number (or school attending for minors) of all household members.

Printed Name (Head of Household)		Social Security Number
Address	City	State Zip
Telephone Number		Date of Birth

Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending

INSTRUCTIONS: All members of the household, 18 years of age and older must sign below.

Signature – Head of Household	Date
Signature – Other Adult	Date
Signature – Other Adult	Date
Signature – Other Adult	Date

OMB Control # 2502-0581
Exp. (11/30/2015)

Optional and Supplemental 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.

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

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.

Signature of Applicant **Date**

Optional and Supplemental Contact Information for HUD-Assisted Housing Applicants

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

Applicant Name:

Mailing Address:

Telephone No: **Cell Phone No:**

Name of Additional Contact Person or Organization:
DMH Housing Job and Development Division - Federal Housing Subsidies Unit

Address: 510 S. Vermont Ave., 17th Floor, LA, CA 90020

Telephone No: 213-943-8805 **Cell Phone No:** n/a

E-Mail Address (if applicable):
FHSU@dmh.lacounty.gov

Relationship to Applicant: Housing Liaison

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.

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Signature of Applicant **Date**

Tenant ID:

Los Angeles County Development Authority
Free Language Services

Do you need an interpreter to do business with the Los Angele County Development Authority?

The Los Angeles County Development Authority (LACDA) is committed to ensuring fair housing for applicants and participants of all housing programs we administer. If you require an interpreter to do business with the LACDA, please let us know right away.

Do I Qualify for Free Language Services?

If your primary language is not English, you may qualify for free language services if:

1) You do not speak, read, or write in English, or
2) You do not feel you are proficient speaking, reading, or writing in English.

You may speak English well, but do not feel comfortable writing in English. Please let us know and we can help you.

How Do I Ask for Free Language Services?

Please indicate your primary language in your reexamination or application packet and let us know if you need language services. Also, you may tell your case worker or one of the lobby staff at the LACDA that you need an interpreter to do business with us and one will be provided. Once we know you require an interpreter, we will provide one for you when you have contact with the LACDA.

Can I Use My Own Interpreter?

Yes, most of the time you can use your own interpreter. There are certain circumstances when you may not:

1) If you participate in a voucher issuance briefing or a hearing;
2) If you bring a minor child to interpret for you;
3) If you bring someone who is not able to interpret the conversation well.

Can I Receive Forms in My Primary Language?

The LACDA has translated many of its forms into Spanish. The LACDA will continue to translate its forms into additional languages as needed. If we do not have forms translated into your primary language yet, we will translate the form to you verbally.

Will the LACDA Provide a Sign Language Interpreter?

Yes. Please let us know as soon as possible before your appointment. Once we know you require a sign language interpreter, we will provide one for you when you have contact with the LACDA.

Can I File a Complaint if I Feel I Was Unfairly Denied Language Services?

Yes, you may file a complaint by writing to the following address and telling us what happened:

Los Angeles County Development Authority
Attention: LEP Coordinator
700 W. Main Street
Alhambra, CA 91801

CITIZENSHIP DECLARATION

INSTRUCTIONS: Complete this form for each member of the household listed on the Family Summary Sheet.

LAST NAME: _____

FIRST NAME: _____ MIDDLE NAME: _____

RELATIONSHIP TO HEAD OF HOUSEHOLD: _____ SEX: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NO.: _____ ALIEN REGISTRATION NO.: _____

ADMISSION NUMBER:_____ if applicable, (this is an 11 digit number found on INS Form I-94, Departure Record).

NATIONALITY:_____ (Enter the foreign nation or country to which you owe legal allegiance. This is normally, but not always, the country of birth.)

SAVE VERIFICATION NO. _____
(To be entered by PHA.)

INSTRUCTIONS: Complete the Declaration below by printing or typing the person's first name, middle initial, and last name in the space provided. Then review the blocks designated below and complete either block number 1, 2, or 3:

DECLARATION

I, _____ hereby declare, under penalty of perjury, that I am: _____

(print or type first name, middle initial, last name)

☐ 1. **a citizen or national of the United States**

If you check this block, no further information is required. Sign and date below and forward this form to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who resides in the assisted unit and who is responsible for the child should sign and date below.

☐ 2. **a noncitizen with eligible immigration status as evidenced by one of the documents listed below:**

NOTE: If you checked this block and you are 62 years of age or older, you need only submit a proof of age document together with this form, and sign below:

If you checked this block and you are less than 62 years of age, you should submit the following documents:

a. Verification Consent Format

AND

b. One of the following documents:

(1) Form I-551, *Permanent Resident Card*

(2) Form I-94, Arrival-*Departure Record*, with one of the following annotations:

(a) "Admitted as Refugee Pursuant to section 207";

(b) "Section 208" or "Asylum";

(c) "Section 243(h)" or "Deportation stayed by Attorney General"; or

(d) "Paroled Pusuant to Sec. 212(d)(5) of the INA."

(3) If Form I-94, *Arrival-Departure Record*, is not annotated, it must be accompanied by one of the following documents:

(a) A final court decision granting asylum (but only if no appeal is taken);

(b) A letter from an DHS asylum officer granting asylum (if application was filed on or after October 1, 1990) or from an DHS district director granting asylum (if application was filed before October 1, 1990);

(c) A court decision granting withholding or deportation; or

(d) A letter from an DHS asylum officer granting withholding of deportation (if application was filed on or after October 1, 1990).

(4) A receipt issued by the DHS indicating that an application for issuance of a replacement document in one of the above-listed categories has been made and that the applicant's entitlement to the document has been verified.

(5) Other acceptable evidence. If other documents are determined by the DHS to constitute acceptable evidence of eligible immigration status, they will be announced by notice published in the Federal Register.

If this block is checked, sign and date below and submit the documentation required above with this declaration and a verification consent format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and responsible for the child should sign and date below.

If for any reason, the documents shown in subparagraph 2.b. above are not currently available; complete the Request for Extension block below.

REQUEST FOR EXTENSION

☐ I hereby certify that I am a noncitizen with eligible immigration status, as noted in block 2 above, but the evidence needed to support my claim is temporarily unavailable. Therefore, I am requesting additional time to obtain the necessary evidence. I further certify that diligent and prompt efforts will be undertaken to obtain this evidence.

☐ 3. **not contending eligible immigration status and I understand that I am not eligible for financial assistance.**

If you checked this block, no further information is required and the person named above is not eligible for assistance. Sign and date below and forward this form to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult living in the unit and responsible for the child should sign and date below.

_____ _____

Signature Date

Check here if adult signed for a child: ☐

DECLARACIÓN DE CIUDADANÍA

INSTRUCCIONES: Complete este formulario para cada miembro de la familia que se encuentre en la lista de la hoja de resumen familiar.

APELLIDO: _____

PRIMER NOMBRE: _____ SEGUNDO NOMBRE: _____

RELACIÓN CON EL
CABEZA DE FAMILIA: _____ SEXO: _____ FECHA DE NACIMIENTO: ___

NO. DE SEGURO SOCIAL: _____ NO. DE REGISTRO DE EXTRANJERO: _____

NÚMERO DE ADMISIÓN: _____ si aplica, (es un número de 11 dígitos que se encuentra en el formulario I-94 del INS, Registro de salida).

NACIONALIDAD: _____ (Indique la nación o el país extranjero al que debe lealtad legal. Normalmente es el país de nacimiento, pero no siempre).

NO. DE VERIFICACIÓN SAVE _____

(Debe introducirse por la PHA.)

INSTRUCCIONES: Complete la declaración a continuación escribiendo con letra de molde o a máquina el nombre, la inicial del segundo nombre y los apellidos de la persona en el espacio previsto. A continuación, revise los bloques designados a continuación y complete el bloque número 1, 2 ó 3:

DECLARACIÓN

Yo, _____ por medio de la presente declaro, bajo pena de perjurio, que soy: _____

(escriba con letra de molde el nombre, la inicial del segundo nombre y el apellido)

☐ 1. **un ciudadano o nacional de Estados Unidos**

Si marca esta casilla, no se requiere más información. Firme y coloque la fecha a continuación y envíe este formulario al nombre y la dirección especificados en la notificación adjunta. Si se marca esta casilla en nombre de un niño, el adulto que reside en la unidad asistida y que es responsable del niño debe firmar y escribir la fecha a continuación.

☐ 2. **un no ciudadano con estatus de inmigración elegible, como lo demuestra uno de los documentos enumerados a continuación:**

NOTA: Si marcó esta casilla y tiene 62 años o más, sólo tiene que presentar un documento que acredite su edad junto con este formulario, y firmar a continuación:

Si marcó esta casilla y tiene menos de 62 años, debe presentar los siguientes documentos:

a. Formato de consentimiento de verificación

Y

b. Uno de los siguientes documentos:

(1) Formulario I-551, *Tarjeta de residente permanente*
(2) Formulario I-94, *Registro de Llegada-Salida*, con una de las siguientes anotaciones:
  (a) "Admitido como refugiado en virtud del artículo 207";
  (b) "Artículo 208" o "Asilo";
  (c) "Artículo 243(h)" o "Deportación suspendida por el Fiscal General"; o
  (d) "Libertad condicional de acuerdo con el art. 212(d)(5) de la INA".
(3) Si el formulario I-94, *Registro de Llegada-Salida*, no está anotado, debe ir acompañado de uno de los siguientes documentos:
  (a) Una resolución judicial definitiva de concesión de asilo (pero sólo si no se toma una apelación);
  (b) Una carta de un oficial del DHS que conceda el asilo (si la solicitud se presentó a partir del 1 de octubre de 1990) o de un director de distrito del DHS que conceda el asilo (si la solicitud se presentó antes del 1 de octubre de 1990);
  (c) Una decisión judicial que conceda la retención o la deportación; o
  (d) Una carta de un oficial de asilo del DHS concediendo la retención de la deportación (si la solicitud se presentó el 1 de octubre de 1990 o después).
(4) Un recibo expedido por el DHS en el que se indique que se ha presentado una solicitud de expedición de un documento sustitutivo en una de las categorías enumeradas anteriormente y que se ha verificado el derecho del solicitante al documento.
(5) Otras pruebas aceptables. Si el DHS determina que otros documentos constituyen una prueba aceptable de la condición de inmigrante elegible, se anunciarán mediante un aviso publicado en el Registro Federal.

Si esta casilla está marcada, firme y escriba la fecha a continuación y envíe la documentación requerida anteriormente con esta declaración y un formato de consentimiento de verificación al nombre y la dirección especificados en la notificación adjunta. Si se marca esta casilla en nombre de un niño, el adulto que residirá en la unidad asistida y que es responsable del niño debe firmar y escribir la fecha a continuación.

Si, por cualquier motivo, los documentos indicados en el apartado 2.b. anterior no están disponibles actualmente, complete el Bloque de solicitud de prórroga a continuación.

SOLICITUD DE PRÓRROGA

☐ Por medio de la presente certifico que soy un no ciudadano con estatus de inmigración elegible, como se indica en el bloque 2 anterior, pero las pruebas necesarias para apoyar mi solicitud no están temporalmente disponibles. Por lo tanto, solicito más tiempo para obtener las pruebas necesarias. Asimismo, certifico que se realizarán esfuerzos diligentes y oportunos para obtener estas pruebas.

☐ 3. **no disputo un estatus de inmigración elegible y entiendo que no soy elegible para obtener asistencia financiera.**

Si marcó esta casilla, no se requiere más información y la persona mencionada no es elegible para obtener asistencia. Firme y coloque la fecha a continuación y envíe este formulario al nombre y la dirección especificados en la notificación adjunta. Si se marca esta casilla en nombre de un niño, el adulto que vive en la unidad y es responsable del niño debe firmar y y escribir la fecha a continuación.

_____ _____

Firma Fecha

Marque aquí si el adulto firmó por un niño: ☐

HOUSING AUTHORITY

Client No:

CONSENT FORM TO VERIFY IMMIGRATION STATUS WITH THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS)

CONSENT: I consent to allow the Housing Authority to request and to obtain information from the U.S. Citizenship and Immigration Services (USCIS) for the purpose of verifying my eligibility and level of benefits under the Housing Authority's assisted housing programs. I understand that the Housing Authority cannot use it to delay, deny, or terminate housing assistance because of the immigration status of a family member, except as provided in the Department of Housing and Urban Development (HUD) regulations. In addition, I understand I must be given an opportunity to contest the determination with the USCIS or the Housing Authority or both.

Signatures:

ADULT(S): AGE 18 OR OVER

Head of Household (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Spouse (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date

MINOR(S): UNDER AGE 18

Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date

Who Must Sign: In order to be eligible to receive housing assistance, each noncitizen adult or minor applying for, or currently receiving, housing assistance must be lawfully within the U.S. Please read the Verification Consent Form carefully and sign and return as directed. Please feel free to consult with an immigration lawyer or other Immigration expert of your choosing.

Privacy Act Statement: The information on this form is being collected by Housing Authority to determine the applicant's or participant's eligibility for housing assistance. The Housing Authority may release this information, without responsibility for the further use or transmission of the evidence by the entity receiving it to: (1) HUD, as required by HUD; and (2) to the USCIS for purposes of verification of the Immigration status of each individual and not for any other purpose.

Penalties for misusing this Consent: HUD, the Housing Authority and any owner (or any employee of HUD, the Housing Authority 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 on the consent form is restricted to the purposes cited on the form. Any person who knowing or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or resident/program participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or resident/program 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 Housing Authority or the owner responsible for the unauthorized disclosure or improper use.

AUTORIDAD DE LA VIVIENDA

Client No:

FORMULARIO DE AUTORIZACIÓN PARA VERIFICAR EL ESTADO DE INMIGRACIÓN CON EL SERVICIO DE CIUDADANÍA E INMIGRACIÓN DE ESTADOS UNIDOS (USCIS, por sus siglas en inglés)

AUTORIZACIÓN: Le concedo permiso a la Autoridad de la Vivienda a que solicite información del Servicio de Ciudadanía e Inmigración de Estados Unidos (USCIS, por sus siglas en inglés) con el fin de verificar mi elegibilidad y nivel de beneficios dentro de los programas de viviendas subsidiadas de la Autoridad de Vivienda. Tengo entendido que la Autoridad de Vivienda no puede usar la información para demorar, negar o anular la asistencia de vivienda debido al estado de inmigración de uno de los miembros de la familia, salvo como está estipulado por los reglamentos del Departamento de Vivienda y Desarrollo Urbano (HUD). Además, tengo entendido que se me debe dar una oportunidad para impugnar la determinación con el USCIS o con la Autoridad de Vivienda, o ambas.

Firmas:

ADULTO(S): MAYORES DE 18 Años

Jefe de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Cónyuge (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha

MENORES DE EDAD: MENORES DE 18 Años

Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha

Quién debe firmar: Para ser elegible para la asistencia de vivienda, cada adulto o menor que no sea ciudadano y que esté solicitando o actualmente reciba asistencia de vivienda, debe estar legalmente en los Estados Unidos. Por favor lea cuidadosamente el formulario de autorización de verificación, fírmelo y devuélvalo como se indica. Por favor no dude en consultar a un abogado especializado en asuntos de inmigración u otro perito de inmigración de su elección.

Declaración de Ley de Confidencialidad: La información de este formulario la solicita la Autoridad de Vivienda para determinar la elegibilidad del solicitante o participante para la asistencia de vivienda. La Autoridad de Vivienda puede compartir esta información, sin responsabilidad del uso posterior o envío de evidencia por parte de la entidad que la reciba con: (1) HUD, como lo requiere HUD; y (2) el USCIS para fines de verificación del estado de inmigración de cada individuo y no para otros fines.

Penalidades por el uso inadecuado de esta autorización: HUD, la Autoridad de Vivienda y cualquier propietario (o cualquier empleado de HUD, de la Autoridad de Vivienda o del propietario) estará sujeto a penalidades por divulgaciones sin autorización o por usos inadecuados de la información, según el formulario de autorización.

El uso de la información contenida en este formulario de autorización está limitado a los fines estipulados en el mismo. Cualquier persona que a sabiendas y deliberadamente solicite, obtenga o divulgue cualquier dato usando falsos pretextos con respecto a un solicitante o residente/participante de programa, estará sujeto a un delito menor y será multado hasta $5000. Cualquier solicitante o residente/participante de programa que se vea afectado por la divulgación negligente de información, puede presentar una demanda por daños y solicitar otra compensación, según sea apropiado, en contra de HUD, la Autoridad de Vivienda o el propietario responsable por la divulgación sin autorización o el uso inadecuado de la misma.

Tenant ID:

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL DEPARTMENT OF PUBLIC SOCIAL SERVICES INFORMATION

THE LOS ANGELES COUNTY DEVELOPMENT AUTHORITY (LACDA) REQUIRES YOUR SIGNATUREON THIS CONSENT FORM TO VERIFY INCOME FROM PROGRAMS ADMINISTERED BY THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS). DPSS, NOR ANY PROGRAM IT ADMINISTERS, REQUIRES YOUR SIGNATURE ON THIS FORM.

As a requirement of LACDA's housing assistance programs, I consent to allow the LACDA to request and obtain income information from DPSS for the purpose of verifying my eligibility and level of benefits under the U.S. Department of Housing and Urban Development's assisted housing programs. I understand that by signing below, DPSS will share the information they have about me, including whether I receive public assistance, the amount of any assistance, first and last name of all persons receiving aid, authorized amount for the payee only, case approval date, termination date of aid and the sanctions/incomereduction information.

Instructions:
The box below must be completed for any household member(s) that receive Public Assistance Benefits administered by DPSS. You must provide the member first name, last name, and benefit type.

Household Member Name		Income Type
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

I understand that I have a right to the privacy of my personal information. I understand that provisions of law protect my information and identity as an applicant or recipient of public assistance.

I understand that by signing this below, I am voluntarily authorizing DPSS, its agents and employees to share the information they have about me. I acknowledge that before signing this Authorization Form, I have carefully read and fully understand its terms. I understand that my refusal to sign this Authorization Form will not impact the services I currently receive or am eligible to receive through DPSS; however, refusal to sign may lead to termination of my housing assistance provided by the LACDA. I understand that I have the right to revoke this authorization at any time by saying so in writing.

This consent form expires 15 months from the date it is signed.

Household Member Name (print name)	Signature	Date
Household Member Name (print name)	Signature	Date
Household Member Name (print name)	Signature	Date
Household Member Name (print name)	Signature	Date

HOUSING COMMUNITY ECONOMIC
LACDA
Los Angeles County Development Authority

MAIN OFFICE
700 W. Main Street, Alhambra, CA 91801
Tel: 626-262-4510 TDD: 626-943-3898
www.lacda.org

CERTIFICATION OF NO CONFLICT OF INTEREST

***By checking the appropriate box and signing below*,** I certify that I have read and understood the following Continuum of Care Program No Conflict of Interest prohibition which is applicable to me:

PROHIBITIONS

APPLICANT OR PARTICIPANT

☑ I hereby certify that I nor any person listed under the household composition of my Los Angeles County Development Authority (LACDA) application have, nor will I have, a relationship (by family, marriage or domestic partnership) with employees of the LACDA or the Service Provider, DMH /_____, who has involvement with the file of or who exercises any function or responsibilities regarding a matter relating to anyone who is an applicant or participant in the Continuum of Care Program.

_____
Print Full Name

_____ _____
Signature Date

SERVICE PROVIDER

☑ I hereby certify that I ***do not***, nor will I have, a relationship (by family, marriage or domestic partnership) with any applicant or participant of the above named Program; while an employee of the Service Provider, DMH /_____, who is subcontracted through the LACDA, and has involvement with the file and/or exercises functions or responsibilities regarding matters relating to Continuum of Care Program applicants or participants.

As such, no covered person, meaning a person who is an employee, agent, consultant, officer, or elected or appointed official of the above named service provider and who exercises or has exercised any functions or responsibilities with respect to activities assisted under this program, or who is in a position to participate in a decision-making process or gain inside information with regard to activities assisted under this program, may obtain a financial interest or benefit from an assisted activity, have a financial interest in any contract, subcontract, or agreement with respect to an assisted activity, or have a financial interest in the proceeds derived from an assisted activity, either for him or herself or for those with whom he or she has immediate family or business ties, during his or her tenure or during the one-year period following his or her tenure.

_____ _____
Print Full Name Work Title (if applicable)

_____ _____
Signature Date

County of Los Angeles - Department of Mental Health
Housing and Job Development Division

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 IBHIS #

DMH /
Agency/Program

Independent Living Supports/Assistance Needed:

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

Housing Plan:

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

Who will live with the client? _____

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

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

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

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

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

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

If yes, what accommodations? _____

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

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

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

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

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

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

☐ Homeless Section 8 ☐ Continuum of Care (CoC) ☐ Section 8 ☐ Project Based Section 8/CoC housing

If yes, complete the questions on the following page:

_____ _____

Print Client Name IBHIS #

DMH / _____

Agency/Program

Continuum of Care (CoC) 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

client ever been evicted from a Governmental subsidized housing program (Sec. 8, CoC 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

Continuum of 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 IBHIS #

DMH / _____

Agency/Program

Provider Signature: _____ Client Signature: _____

LOS ANGELES COUNTY DEVELOPMENT AUTHORITY
CONTINUUM OF CARE PROGRAM
HOUSING INTAKE ASSESSMENT

_____ _____

Date of Assessment Client Name

Housing Situation:

Does the client meet HUD's definition of homeless? ☐ Yes ☐ No

What is the client's current living situation?

☐ Motel ☐ Family/Friends ☐ Other: _____

☐ Transitional Housing ☐ Homeless Shelter

☐ Street/Car/Parks (specify names of closest cross streets): _____

Is client fleeing from domestic violence? ☐ Yes ☐ No

Is the client disabled? ☐ Yes ☐ No

Financial Situation:

Does the client's meet the income eligibility requirements for Continuum of Care? ☐ Yes ☐ No

Check all sources of client's income:

☐ Food Stamps ☐ SSI ☐ GR VA

☐ SDI ☐ SSDI ☐ Employment None

☐ Unemployment Insurance ☐ Child Support ☐ Other (i.e. family support)

Housing Plan:

What are the client's housing goals?

_____

_____

_____

What are the client's barriers to permanent housing?

_____

_____

_____

What are the steps/plans that will be taken to address those barriers in helping the client achieve the housing goal?

_____

_____

_____

_____

Supportive Services:

Please check all services in which the client is in need of:

☐ Annual assessment of service needs ☐ Assistance with Moving Costs ☐ Case Management

☐ Housing search/counseling services ☐ Utility deposits ☐ Life Skills Training

☐ Therapy/Mental Health Services ☐ Legal services ☐ Outreach services

☐ Employment Services ☐ Educational Services ☐ Food/Meals

☐ Substance Abuse Treatment Services ☐ Child Care Services ☐ Outpatient Health Care Services

☐ Transportation

Completed By: _____ _____

Staff Signature Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOUSING AND JOB DEVELOPMENT DIVISION

CONTINUUM OF CARE PROGRAM
SERVICE PROVIDER RESPONSIBILITY FORM

To be completed and signed by the DMH or ICMS Program/Agency Manager:

Name of Client: _____

Name of Client's DMH Treatment Provider Agency: DMH / _____

Provider Number: _____

The program manager of the client's DMH mental health treatment provider agency will ensure that the Continuum of Care (CoC) participant will have an assigned case manager who will be responsible for the following, for the duration of the client's participation in the program:

- Use a Housing First approach to assist the client with immediate access to housing and the supports needed to retain housing.
- Assist the client with completing the required documents by the Housing Authority of the City of Los Angeles (HACLA) or Los Angeles County Development Authority (LACDA), and accompany the participant to scheduled meetings with the Housing Authorities.
- Assist the client with a housing search.
- Send signed lease agreements to the DMH - Housing & Job Development Division, Federal Housing Subsidies Unit (FHSU) when received.
- Ensure that the agency remains updated regarding the client/participant's current contact information.
- Maintain, at a minimum, monthly contact with the participant and quarterly home visits.
- Conduct needs assessments to determine the appropriate linkage(s) to community-based services such as health care, childcare, alcohol and other substance abuse treatment, education and/or job training, and other services essential for achieving and maintaining independent living.
- Conduct ongoing assessments/evaluations to monitor the client's progress and provide appropriate interventions as needed.
- Provide a Housing Annual Assessment form that incorporates the client's 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 treatment plan and/or problem list annually and include any appropriate housing-related goals.
- Document housing supportive services in the client's clinical file, including but not limited to: CES survey completion and entry into HMIS, assistance with applications,

accompanying the client to the Housing Authority, housing search, and housing stabilization.

- Submit signed MH 677, Authorization 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 LACDA) 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 to 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 Quarterly Report Survey (HACLA) and Client Progress Report - Quarterly Review (LACDA). These records will be subject to audit by HUD and the local Housing Authority administering the grant.

- Participate in regularly scheduled DMH 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 (LACDA).

- 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 CoC 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 CoC.

Case Manager's Name (Print): _____

Case Manager's Signature: _____ Date: _____

Case Manager's Program/Agency Affiliation: _____

Program/Agency Manager's Name (Print): _____

Program/Agency Manager's Signature: _____ Date: _____

Manager's Agency Affiliation: DMH / _____

Provider Number: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CONTINUUM OF CARE
PARTICIPANT AGREEMENT

As a participant in the Continuum of Care (CoC) Program with the Housing Authority of the City of Los Angeles (HACLA) or Los Angeles County Development Authority (LACDA), **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 as long as I am a participant in the CoC Program.
2. Participate in the development of my treatment plan and/or problem list 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: _____

LACDA CoC Application Checklist

LAHSA's Required Forms

__ 1. HMIS print out
__ 2. Dedicated Plus Cover Checklist – Form 2835
__ 3. Dedicated Plus Homelessness History Form – continuation of Form 2835
__ 4. Verification of Disability – Form 2833 or written verification from the Social Security Administration

If the HMIS print out does not verify 12 months of homelessness within the last 36 months, then the following form is needed

__ 4. Homeless Verification form (if applicable) – Form 6053

For any month the applicant self-certifies the following is needed (one form per month of self-certification with at least two attempts noted)

__ 5. Agency Due Diligence form (if applicable) – Form 1446

LACDA Required Application Packet

__ 1. LACDA Referral Form
__ 2. Coordinated Entry System (CES) referral form
__ 3. LACDA Application
    i. 11-page application (All "yes" answer require supporting documents)
        a. All income and asset supporting documents must be dated within 60 days of receipt
__ 4. Authorization for Release of Information (must be signed by all adults)
__ 5. HUD 92006 Form
__ 6. Citizenship Declaration
    i. one form per household member
__ 7. DPSS Release
__ 8. Certification of No Conflict of Interest
__ 9. Housing Intake Assessment
__ 10. Identification Documents
    i. Identification or Driver License card for all adults
    ii. Birth Certificates for minors
    iii. Social Security number verification for all

Referring Agency Form

__ 1. Supportive Service agreement with applicant

PLACE HERE

INCOME VERIFICATION including the following:

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

See other examples of Income Verification on
Continuum of Care Program Application Checklist

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 housing application.

-and-

Copy of each household member's Social Security card. The Housing Authority recommends that the Social Security cards are signed.

DedicatedPLUS Verification Packet
PART A: DedicatedPlus Cover Checklist

Date Associated with this Verification Packet

HMIS/Clarity ID

Name of Program Applicant

Date of Birth

Agency Contact
(Name of Person who can answer questions about this packet)

Agency Name

Phone Number of Agency Contact

Email Address for Agency Contact

DedicatedPLUS Homelessness Category
(Pick One: Check the box for the DedicatedPLUS category that the client is attempting to qualify under)

- ☐ **Category 1**: Chronically Homeless *[Attach: Homelessness History Form and supporting documentation]*
- ☐ **Category 2**: In Transitional Housing (TH) that is being eliminated & CH at TH entry *[Attach: TH Program Enrollment Record, Documentation of Chronic Homelessness a t TH Entry, and Letter certifying program closure]*
- ☐ **Category 3**: Currently homeless, was admitted and enrolled in PSH within last year, was unable to maintain housing, and was CH at time of entrance into PSH *[Attach: PSH Program Exit Record dated within the last year, and Documentation of Chronic Homelessness at PSH Entry]*
- ☐ **Category 4**: In Joint TH-RRH Project & CH at TH entrance *[Attach : Joint TH-RRH Program Enrollment Record, and Documentation of Chronic Homelessness at Joint TH-RRH Entry]*
- ☐ **Category 5**: Is homeless, in safe haven, or in emergency shelter for at least 12 months in the last three years but has not done so on four separate occasions *[Attach: Homelessness History Form and supporting documentation]*
- ☐ **Category 6**: Receiving assistance through a VA funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system. *[Attach: VA Homelessness Verification Form]*

Verification of Disability
(Pick One: Check the box to indicate the type of disability verification that is attached to this packet)

Third Party documentation is required at the time of application. Any of the sources below can be used to fulfill the Third Party documentation requirement. 2, For Categories 3, 4, or 6, this section may be satisfied by attaching the verification of disability that was used to qualify for the original project enrollment.

- ☐ Verification of Disability Status By a Licensed Professional *[Attach: Verification of Disability Form or a comparable written verification letter]*
- ☐ Written verification from the Social Security Administration *[Attach: Document from Social Security Administration with individual's name and verification of disability status, such as receipt of disability benefits]*

Verification of Current Homelessness
(Pick One: Check the box for the type of current homelessness verification attached.)

- ☐ HMIS Record of active enrollment in a homeless program *[Attach: Homeless Status Timeline; or HMIS Client Summary; or Enrollment Record]*
- ☐ Homelessness Verification Form *[Attach: Homelessness Verification Form - completed by 3rd party]*

PART B: DedicatedPlus Homelessness History Form

HMIS/Clarity ID

Name of Program Applicant

Agency Contact

Agency Name

Contact Phone

Contact Email

Instructions:

Section 1. Fill in the name of each month and year in which the client is known to have experienced homelessness, starting with the current month and listing the remaining months in reverse order. Once 12 months of homelessness have been documented for the client, no further months of documentation are required. It is ok to pre-fill all months in reverse chronological order.

Section 2. Review the HMIS Timeline and talk with the client to determine if they experienced homelessness in any month within the past 3 years. (Only 12 months need to be documented.) In the row for each known month, insert an "X" in the "Known Period of Homelessness" column and add an "X" in the appropriate (green) column to designate the place in which the person experienced homelessness.

Section 3. Begin collecting documentation for these periods. As documentation is compiled, indicate an "X" in the relevant documentation column. Documentation is only needed for 12 months. Documentation from HMIS or a third party is needed for at least 4 months. If third party documentation cannot be readily collected, the client can self-certify homelessness for up to 8 of the 12 months. If self-certification of homelessness is used, attempts to collect third party documentation must be recorded on a due diligence form.

1. Months within the last 3 Years		**2.** Place Client Experienced Homelessness						**3.** Documentation of Homelessness				**4.** Page #
Month	**Year**	**Known Period of Homelessness** (Insert "X" If month of homeless)	Place not meant for human habitation	Emergency Shelter	Safe Haven	Hotel/Motel Paid by an Agency	Institution for less than 90 days, and Homeless at Entry	**HMIS Record** (Timeline; Client Summary; or Enrollment printout) or other Enrollment printout	**Homelessness Verification Form** - completed by **3rd party**	**Institutional Paperwork** (Record or Letter specifying Homeless at Entry with Stay < 90 days)	**Homelessness Verification Form - self-certified** by Client and **Due Diligence Form**	Assemble homelessness history documentation in order of months listed below. **Number all pages and list the respective page # here.**
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PART B: DedicatedPlus Homelessness History Form

1. Months within the last 3 Years		**2.** Place Client Experienced Homelessness						**3.** Documentation of Homelessness				**4.** Page #
Month	**Year**	**Known Period of Homelessness** (Insert "X" If month of homeless)	Place not meant for human habitation	Emergency Shelter	Safe Haven	Hotel/Motel Paid by an Agency	Institution for less than 90 days, and Homeless at Entry	**HMIS Record** (Timeline; Client Summary; or Enrollment printout) or other Enrollment printout	**Homelessness Verification Form** - completed by **3rd party**	**Institutional Paperwork** (Record or Letter specifying Homeless at Entry with Stay < 90 days)	**Homelessness Verification Form - self-certified** by Client and **Due Diligence Form**	Assemble homelessness history documentation in order of months listed below**. Number all pages and list the respective page # here.**
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# MONTHS KNOWN HOMELESS												

Los Angeles Continuum of Care
Homelessness Verification

Please complete all sections of this form thoroughly to ensure validity and completeness. This form can be used across ALL homeless programs within the Los Angeles Continuum of Care. For the CoC Program eligibility, Sections 1, 2, and 3A must be completed. *The verification does not expire.*

Name of Program Applicant

HMIS/VSP #

Name of Person Completing Form

Agency Name (if applicable)

Contact Email

Contact Phone

Name of Person Providing Oral Statement to Individual Completing this Form (if applicable):

1. Description of Encounter or Observation

Choose the relevant option that best describes the encounter of observation used to verify the period(s) homelessness. For multiple verification instances involving different locations or sources, complete separate forms for each instance. Please select only one option per form

☐ As a representative of an emergency shelter program, I can confirm that the household was a program participant in the period(s) listed below.

☐ As a representative of a safe haven program, I can confirm that the household was a program participant in the period(s) listed below.

☐ As a representative of a non-profit organization or government agency, I can confirm that my agency paid for at least 51% of the cost for a hotel/motel stay in the period(s) listed below.

☐ In my professional capacity, the household reported that they were residing in the location listed, and in my professional judgment I found this to be truthful.

☐ I observed the person/household sleeping in the evening/early morning hours or observed signs of encampment that made me believe they were living in this location in the period(s) listed below.

☐ Self Certification: I experienced homelessness in the period(s) and locations listed below.
Please include an accompanying Agency Due Diligence Form 1446 per month of self-certification.

2. Episodes of Homelessness

List all months including the current month of homelessness that pertains to the description above. Each month must have a corresponding location number.

Month/Year (at least one day in the month)	**Location Number**	**Type of Location Where Household was Residing** (Use numbers from the list to note the location in which the household was residing)
		1. Unsheltered location - Other than Encampment 2. Unsheltered location - Encampment 3. Housing/Building w/ No running water, electricity 4. Vehicle - Safe Parking Location 5. Vehicle - Other Location 6. Emergency Shelter 7. Safe Haven 8. Hotel/Motel (paid for by organization) 9. RV/Camper w/ no running water, electricity * In some circumstances, some of these locations may not count towards periods of homelessness, but time should be documented so it can be part of a client's history of homelessness and housing. 10. Undisclosed 11. Jail 12. Hospital 13. Substance Use Treatment Facility/Rehab 14. Transitional Housing Program 15. House/Apartment - Renter 16. House/Apartment - Owner 17. Living with friend or family member

3A. Current Homelessness

Indicate the most recent date when the individual was known to be in this location and specify the location type. If this form is for verifying ongoing homelessness for a housing application, the date provided must be within 7 day of application submission. Please ensure the month listed below is also indicated in Section 2.

Most Recent Date Person was Known to be in this location (MM/DD/YYYY)	Type of Location Where Household was Residing (Enter number from list below)

3B. Cause of Current Homelessness

Please check the appropriate box if the above indicated episode was caused due to a situation described below.

☐ Self Certification: I am experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other dangerous, traumatic, or life-threatening conditions related to the violence against me or a family member in my or my family's current housing situation, including where the health and safety of children are jeopardized; I have no other safe residence; and I lack the resources or support networks to obtain other safe permanent housing.

☐ In my professional capacity, I can confirm that the participant: is experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized; has no other residence; and lacks the resources or support networks to obtain other safe permanent housing.

☐ None of the above apply.

4. Certification

If program applicant is self certifying under Section 1, they must certify by signing below. In cases of all other encounters or descriptions, the individual verifying must sign below.

I certify that, to the best of my knowledge and belief, all the information presented above is true, accurate, and complete.

Printed Name

Contact Phone Number or Email

Signature

Date

Agency Due Diligence to Acquire 3rd Party Homelessness Verification

HMIS ID

Name of Program Applicant

Instructions: Every provider is required to do their due diligence in obtaining 3rd party verification of an applicant's homelessness history to satisfy HUD's legal requirement for verification of a person's eligibility. One form should be used for each third party source. At least two attempts to reach that source are required before relying on client self-certification.

This document is intended to document and certify the provider's due diligence efforts. All self-certification of homelessness must be accompanied by this form. If the applicant is verifying homelessness using a Third Party, and/or Observation of Homelessness, this form is not required. Each month of Self-Certification of Homelessness requires one Agency Due Diligence to Acquire 3rd Party Homelessness Verification form.

Person Completing Form

Agency Name (if applicable)

Contact Phone

Contact Email

Name of Person Providing Oral Statement to Individual Completing this Form (if applicable)

Month/Year of homelessness being verified

By completing this form, the provider certifies they have taken the following steps to obtain third-party verification from the agency/person listed below, and have the supporting in the file to support these efforts.

Date of Effort	**Description** (Include location, type of interaction, name of person contacted, contact phone or email, how the person was contacted and relationship of the person to the program applicant)	**Outcome of Contact** (e.g. no response, declined to provide third party verification)*

* If the person discloses they do not know the program applicant, another contact should be identified for verification.

Staff Name

Agency Name

Staff Title

Staff Email

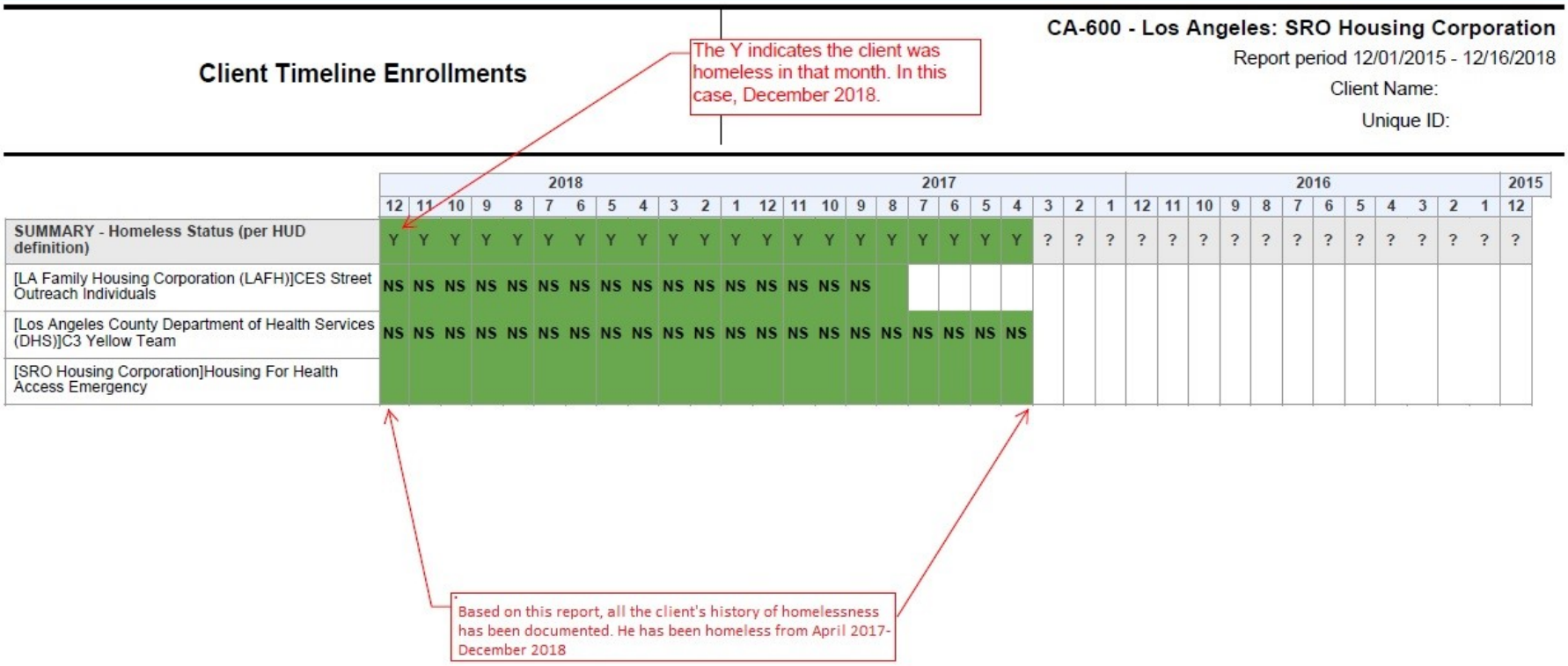
Staff Phone

Staff Signature

Date

Form 1446

SAMPLE
PRINTOUT FROM HMIS



	2018																2017							2016												2015
	12	11	10	9	8	7	6	5	4	3	2	1	12	11	10	9	8	7	6	5	4	3	2	1	12	11	10	9	8	7	6	5	4	3	2	1	12
SUMMARY - Homeless Status (per HUD definition)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?
[LA Family Housing Corporation (LAFH)]CES Street Outreach Individuals	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS																				
[Los Angeles County Department of Health Services (DHS)]C3 Yellow Team	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS																
[SRO Housing Corporation]Housing For Health Access Emergency																																					

VERIFICATION OF DISABILITY FORM
Continuum of Care Program

Date: _____

Dear Physician/ Qualified Health Personnel:

_____ has claimed eligibility for a federally funded housing program which requires a household
(Applicant Name)
member to have a qualifying disability. The claim must be certified by a professional licensed by the state to diagnose and treat the disability.

For the purpose of this program, an individual or qualifying household member must meet the definition of 'homeless individual with a disability' which can be found in Section 401 (9) of the McKinney-Vento Act, as amended by the HEARTH Act which is an individual who is homeless and has a disability that is expected to be long-continuing or of indefinite duration; substantially impedes the individual's ability to live independently and could be improved by the providing of more suitable housing conditions. The disability could be any physical, mental, or emotional impairment, including impairment caused by alcohol and/or drug abuse, post-traumatic stress disorder, or brain injury; a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency of acquired immunodeficiency syndrome.

Requested by: _____
(Name of Housing/ Service Provider)

SECTION TO BE COMPLETED BY APPLICANT:

Applicant's Release Authorization:

I, _____ hereby authorize release of the information below: _____ on _____.
(Applicant Name) **(Signature of Applicant)** **(Effective Date)**

MEDICAL CERTIFICATION
(SECTION TO BE COMPLETED BY LICENSED PROFESSIONAL)

As a professional licensed by the state to diagnose and treat this disability, it is my determination that the above applicant,

_____, does have a disability as defined above as of _____.
(Applicant Name) **(Date)**

Disability is: (Please check the box that applies)

- ☐ Physical Illness or Impairment
- ☐ Serious Mental Illness
- ☐ Substance Use Disorder
- ☐ AIDS or HIV Related Diseases
- ☐ Cognitive Impairments resulting from Brain Injury
- ☐ Post-Traumatic Stress Disorder
- ☐ Developmental Disability
- ☐ Other: _____

Additional information concerning this disability:

This disability is expected to be of long-continuing or of indefinite duration; substantially impairs their ability to live independently and is of such nature that daily functioning and the disability could improve under more suitable housing conditions. ☐ YES ☐ NO

Printed Name: _____ **License Number:** _____

Professional Title: _____ **Phone Number:** _____

Signature: _____ **Date:** _____

Name of Medical Group: _____

Agency Address: _____

Attach Organization Stamp/Card:

DEFINITION OF DISABILITY
COC PROGRAM

To be eligible for assistance under the CoC Program, an individual or family must meet the definition of homeless as set forth in section 578.3 of the CoC Program interim rule as well as any additional eligibility criteria set forth in the CoC Program NOFA under which the project was funded, which we have provided at the end of this response.

Where disability is an eligibility requirement for the project, the recipient must also document the program applicant's disability. As found in the HEARTH: Defining "Homeless" Final Rule, the following documentation of disability is accepted:

1. Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently; OR
2. Written verification from the Social Security Administration; OR
3. The receipt of a disability check; OR
4. Intake staff recorded during initial assessment, observation of behavior that indicates a disability- must submit no later than 45 days of application for assistance, confirmation and evidence as listed in 1, 2, and 3 of the observed disability; OR
5. Other documentation approved by HUD.

If the disability is not in the form of written verification from the Social Security Administration or in the form of a disability check, then the disability must be verified by a written diagnosis from a professional who is licensed by the state to diagnose and treat that condition. The recipient will need to determine whether the professional who plans to provide the written diagnosis meets HUD's requirement for their state.

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**
IBHIS 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 County Development Authority (LACDA), Special Needs Housing Unit.

REDISCLOSURE NOTICE:

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

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

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

Purpose of Disclosure:

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

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

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

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

N O T I C E

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

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

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

EXPIRATION DATE

Expiration Date: This authorization remains valid until the housing subsidies program participant is no longer receiving services through Department of Mental Health's grant with LACDA.

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 Housing and Job Development Division Federal Housing Subsidies Unit, 510 S. Vermont Ave., 17th Floor, Los Angeles, CA 90020. 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 to Release Information

CLIENT #: _____

I authorize the Los Angeles County Development Authority (LACDA) 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 LACDA assisted housing program with the following and their agents or employees. This authorization form is valid throughout the duration of my participation in the LACDA assisted housing program.

☐ Los Angeles County Department of Mental Health

☐ Other (please name): _____

Client's Name: _____

Client's Signature:_____

Date: _____

(04/2016)

Los Angeles Collaborative HMIS Intake and Enrollment Form

Version 2024

Updated 10/1/2023

GREATER LOS ANGELES
HOMELESS MANAGEMENT INFORMATION SYSTEM (LA HMIS)

CONSENT TO SHARE PROTECTED PERSONAL INFORMATION

The LA HMIS is a local electronic database that securely record information (data) about clients accessing housing and homeless services within the Greater Los Angeles County. This organization participates in the HMIS database and shares information with other organizations that use this database. This information is utilized to provide supportive services to you and your household members.

What information is shared in the HMIS database?

We share both Protected Personal Information (PPI) and general information obtained during your intake and assessment, which may include but is not limited to:

- Your name and your contact information
- Your social security number
- Your birthdate
- Your basic demographic information such as gender and Race and Ethnicity
- Your history of homelessness and housing (including your current housing status, and where and when you have accessed services)
- Your self-reported medical history, including any mental health and substance abuse issues
- Your case notes and services
- Your case manager's contact information
- Your income sources and amounts; and non-cash benefits
- Your veteran status
- Your disability status
- Your household composition
- Your emergency contact information
- Any history of domestic violence
- Your photo (optional)

How do you benefit from providing your information?

The information you provide for the HMIS database helps us coordinate the most effective services for you and your household members. By sharing your information, you may be able to avoid being screened more than once, get faster services, and minimize how many times you tell your 'story.' Collecting this information also gives us a better understanding of homelessness and the effectiveness of services in your local area.

Who can have access to your information?

Organizations that participate in the HMIS database can have access to your data. These organizations may include homeless service providers, housing groups, healthcare providers, and other appropriate service providers.

How is your personal information protected?

Your information is protected by the federal HMIS Privacy Standards and is secured by passwords and encryption technology. In addition, each participating organization has signed an agreement to maintain the security and confidentiality of the information. In some instances, when the participating organization is a health care organization,

your information may be protected by the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA).

By signing below, you understand and agree that:

- You have the right to receive services, even if you do not sign this consent form.
- You have the right to receive a copy of this consent form.
- Your consent permits any participating organization to add to or update your information in HMIS, without asking you to sign another consent form.
- This consent is valid for seven (7) years from the date the PPI was created or last changed.
- You may revoke your consent at any time, but your revocation must be provided either in writing or by completing the *Revocation of Consent* form. Each Participating Organization that entered information into HMIS will continue to have access to your PPI, but the information will no longer be available to any other Participating Organization.
- The Privacy Notice for the LA HMIS contains more detailed information about how your information may be used and disclosed. A copy of this notice is available upon request.
- No later than five (5) business days of your written request, we will provide you with:
    - A correction of inaccurate or incomplete PPI
    - A copy of your consent form
    - A copy of your HMIS records; and
    - A current list of participating organizations that have access to your HMIS data.
- Aggregate or statistical data that is released from the HMIS database will not disclose any of your PPI.
- You have the right to file a grievance against any organization whether or not you sign this consent.
- You are not waiving any rights protected under Federal and/or California law.

Right to Make Corrections

If you believe that your PPI in HMIS is incorrect or incomplete, you have the right to request a correction. To ask for either of these changes, send a written request, including the reason why you believe the information is incorrect or incomplete, to the HMIS Administrator of the organization that entered the information into HMIS. The organization may turn down your request if the information:

- Was not created by the organization you are requesting the change from;
- Is not part of the information that you would be allowed to look at and copy;
- Is related to another individual;
- Is found to be correct and complete.
- Is otherwise protected by law.

However, if your request for correction is denied, you have the right to request that the following language is entered next to a particular entry: “The participant disputes the accuracy of this entry.”

SIGNATURE AND ACKNOWLEDGEMENT

Your signature below indicates that you have read (or been read) this client consent form, have received answers to your questions, and you freely consent to have your information, and that of your minor children (if any), entered into the HMIS database. You also consent to share your information with other participating organizations as described in this consent form.

☐ **I consent to sharing my photograph. (Check here)**

Client Name: _____ DOB: _____ Last 4 digits of SS_____

Signature _____Date _____

☐ **Head of Household (Check here)**

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

_____ _____

Print Name of Organization Staff **Print Name of Organization**

_____ _____

Signature of Organization Staff **Date**

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Client Profile

Please note: All questions shaded in dark gray are REQUIRED. All questions in light gray are SOFT REQUIRED. All questions not shaded at all (white) are not required. All questions answered with a * or ** that are followed by a follow-up questions are REQUIRED as well. Please read all parts of the document fully and thoroughly and follow the instructions. Follow this rule throughout the entire survey.

HMIS Consent signed (Release of Information Permission): ☐ No ☐ Yes Date consented (Start date): _____/_____/_____

Social Security Number	_____-_____-_____
Quality of SSN	☐ Full SSN reported ☐ Client doesn't know ☐ Data not collected ☐ Approximate or partial SSN reported ☐ Client prefers not to answer
Last Name	
Middle Name	Suffix:
Maiden Name	
First Name	
Alias	
Quality of Name	☐ Full name reported ☐ Client doesn't know ☐ Data not collected ☐ Partial, street name, or code name reported ☐ Client prefers not to answer
Date of Birth	_____/_____/_____
Quality of DOB	☐ Full DOB reported ☐ Client doesn't know ☐ Data not collected ☐ Approximate or partial DOB reported ☐ Client prefers not to answer
Gender (Please select all that apply)	☐ Woman (Girl, if child) ☐ Client doesn't know ☐ Man (Boy, if child) ☐ Client prefers not to answer ☐ Culturally Specific Identify (e.g., Two-Spirit) ☐ Data not collected ☐ Transgender ☐ Non-Binary ☐ Questioning ☐ Different Identity If Different Identity, Please Specify_____
Pronoun(s): Such as she/her/hers, he/him/his, they/them/theirs,etc.	
Race and Ethnicity	☐ American Indian, Alaska Native, or Indigenous ☐ Native Hawaiian or other Pacific Islander ☐ Asian or Asian American ☐ White ☐ Black, African American, or African ☐ Client doesn't know ☐ Hispanic/Latina/e/o ☐ Client prefers not to answer ☐ Middle Eastern or North African ☐ Data not collected
Tribal Affiliations (if Race is American Indian or Alaskan Native, please note your Tribal Affiliation if known)	

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Primary Language	☐ English ☐ Spanish ☐ French ☐ Italian ☐ German ☐ Greek ☐ Polish	☐ Portugese ☐ Russian ☐ Swedish ☐ American Sign Language ☐ Other (specify:_____) ☐ Client doesn't know ☐ Client prefers not to answer
TB Clearance Date	_____/_____/_____	Clinic:
DPSS ID	_____	
ILP eligibility confirmed? (*to be completed by SPA matcher.***)**	☐ No ☐ Yes	☐ Undetermined
DMH eligibility confirmed?	☐ No ☐ Yes	☐ Undetermined
Reviewed for COVID-19 vulnerability and Project Room Key?	☐ No ☐ Yes ☐ Potentially eligible	☐ N/A (housed) ☐ Missing key data/client follow up necessary
Veteran Status	☐ No ☐ Yes	☐ Don't know ☐ Client prefers not to answer ☐ Data not collected
If the client identifies as "Yes" (**) to veteran status, then the following questions (**except VHA Eligible and VASH Status**) are **required**:	If the client identifies as "Yes" (**) to veteran status, then the following questions (except VHA Eligible and VASH Status) are required:	If the client identifies as "Yes" (**) to veteran status, then the following questions (except VHA Eligible and VASH Status) are required:

If the client identifies as "Yes" (**) to veteran status, then the following questions (**except VHA Eligible and VASH Status**) are **required**:

Dates of military service (Year Only)	_____ to _____		
Veteran Health Administration (VHA) Eligible	☐ No ☐ Yes		
VASH Status	☐ Admitted ☐ Ineligible background (not eligible because of criminal background) ☐ Ineligible case management (ineligible because they currently do not need that level of case management)	☐ Ineligible Veteran Health Administration (VHA) (ineligible because they are not VA healthcare eligible) ☐ Interested list ☐ Needs screening	☐ Vouchered ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Branch of Military	☐ Army ☐ Navy ☐ Coast Guard ☐ Client doesn't know ☐ Air Force ☐ Marines ☐ Space Force ☐ Client prefers not to answer ☐ Data not collected	
Discharge Status	☐ Honorable ☐ Bad conduct ☐ Client doesn't know ☐ General under honorable conditions ☐ Dishonorable ☐ Client prefers not to answer ☐ Under other than honorable conditions (OTH) ☐ Uncharacterized ☐ Data not collected	
Theater of Operations	World War II	Korean War
	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected
	Vietnam War	Persian Gulf War (Operation Desert Storm)
	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected
	Afghanistan (Operation Enduring Freedom)	Iraq (Operation Iraqi Freedom)
	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected
	Iraq (Operation New Dawn)	Other Operations
	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected	☐ No ☐ Client doesn't know ☐ Yes ☐ Client prefers not to answer ☐ Data not collected

Points of Contact – *If three Points of Contact (PoC) are already recorded, please contact all staff before removing a participant to discuss the most appropriate staff to serve a PoC. The program(s) providing housing navigation-type services should serve as PoC.*

First Point of Contact		
Point of Contact Date	_____/_____/_____	
Point of Contact Name		
Point of Contact Phone		Extension:
Point of Contact Email		
Point of Contact Supervisor or Manager Name		
Point of Contact Supervisor or Manager Phone Number		Extension:
Point of Contact Supervisor or Manager Email		
Point of Contact Category	☐ LAHSA Funded Access Center ☐ LAHSA Funded Housing Navigation Program ☐ LAHSA Funded Interim Housing (Bridge) ☐ LAHSA Funded Interim Housing (Crisis) ☐ LAHSA Funded Interim Housing (Host Home) ☐ LAHSA Funded Street Outreach Program ☐ DHS Funded Countywide Benefits Entitlement Services Team (CBEST) ☐ DHS Funded E6 Multi-Disciplinary Outreach Team ☐ DHS Funded Interim Housing	☐ DHS Funded Interim Housing Intensive Case Management (ICMS) Program ☐ DMH Funded Full Service Partnership Program ☐ DMH Funded Housing Specialist and Housing Liaisons ☐ DMH Funded Interim Housing ☐ DMH Funded Recovery Resilience and Reintegration Services ☐ DPH Funded Substance Use Disorder Case Manager ☐ Other (specify:_____)

Second Point of Contact		
Point of Contact Date	_____/_____/_____	
Point of Contact Name		
Point of Contact Phone		Extension:
Point of Contact Email		
Point of Contact Supervisor or Manager Name		
Point of Contact Supervisor or Manager Phone		Extension:

Point of Contact Supervisor or Manager Email		
Point of Contact Category	☐ LAHSA Funded Access Center ☐ LAHSA Funded Housing Navigation Program ☐ LAHSA Funded Interim Housing (Bridge) ☐ LAHSA Funded Interim Housing (Crisis) ☐ LAHSA Funded Interim Housing (Host Home) ☐ LAHSA Funded Street Outreach Program ☐ DHS Funded Countywide Benefits Entitlement Services Team (CBEST) ☐ DHS Funded E6 Multi-Disciplinary Outreach Team ☐ DHS Funded Interim Housing	☐ DHS Funded Interim Housing Intensive Case Management (ICMS) Program ☐ DMH Funded Full Service Partnership Program ☐ DMH Funded Housing Specialist and Housing Liaisons ☐ DMH Funded Interim Housing ☐ DMH Funded Recovery Resilience and Reintegration Services ☐ DPH Funded Substance Use Disorder Case Manager ☐ Other (specify:_____)

Third Point of Contact		
Point of Contact Date	_____/_____/_____	
Point of Contact Name		
Point of Contact Phone		Extension:
Point of Contact Email		
Point of Contact Supervisor or Manager Name		
Point of Contact Supervisor or Manager Phone		Extension:
Point of Contact Supervisor or Manager Email		
Point of Contact Category	☐ LAHSA Funded Access Center ☐ LAHSA Funded Housing Navigation Program ☐ LAHSA Funded Interim Housing (Bridge) ☐ LAHSA Funded Interim Housing (Crisis) ☐ LAHSA Funded Interim Housing (Host Home) ☐ LAHSA Funded Street Outreach Program ☐ DHS Funded Countywide Benefits Entitlement Services Team (CBEST) ☐ DHS Funded E6 Multi-Disciplinary Outreach Team ☐ DHS Funded Interim Housing	☐ DHS Funded Interim Housing Intensive Case Management (ICMS) Program ☐ DMH Funded Full Service Partnership Program ☐ DMH Funded Housing Specialist and Housing Liaisons ☐ DMH Funded Interim Housing ☐ DMH Funded Recovery Resilience and Reintegration Services ☐ DPH Funded Substance Use Disorder Case Manager ☐ Other (specify:_____)

HMIS Intake and Enrollment Form

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Client Contact Information *(Location)*

Address Type:	Name	
□ Home □ Work □ School □ Mailing	Address 1	
	Address 2	
□ Emergency □ Father	City	
□ Mother □ Spouse	State	
□ Temporary □ Other	Zip Code	
□ Legal Guardian □ Message	Email	
□ Management Company □ Forwarding Address	Phone 1	
	Phone 2	

Current Living Situation *(Location)*

Address Type: □ Temporary Date of Engagement _____ / _____ / _____	Client Name	
	Address 1	
	Address 2	
	City	
	State	
	Zip Code	
	Email	
	Phone 1	
	Phone 2	

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Program Entry *– All clients, all fields required unless otherwise noted*

Please note: All questions shaded in dark gray are REQUIRED. All questions in light gray are SOFT REQUIRED. All questions not shaded at all (white) are not required. All questions answered with a * or ** that are followed by a follow-up questions are REQUIRED as well. Please read all parts of the document fully and thoroughly and follow the instructions. Follow this rule throughout the entire survey.

Program Name: _____ **Case Manager:** _____

Home Safe Referral ID: _____

1. Program Start Date	_____/_____/_____
2. Relationship to Head of Household	☐ Self (head of household) ☐ Head of household's other relation member ☐ Head of household's child ☐ Other: non-relation member ☐ Head of household's spouse or partner
4. Enrollment CoC	☐ CA-600 – Los Angeles ☐ CA-607 – Pasadena ☐ CA-614 – San Luis Obispo County ☐ CA-602 – Orange County ☐ CA-611 – Ventura County ☐ CA-606 – Long Beach ☐ CA-612 – Glendale

CES Placement *– Permanent Housing and Transitional Housing only*

5. Was the client placed into this housing program through CES?	☐ No ☐ CES for Single Adults ☐ CES for Families ☐ CES for Youth

Housing Move-In *– Rapid Re-housing, Permanent Housing, and Street Outreach projects only, only required for Head of Household*	
6. Has the client been moved-in to permanent housing?	☐ No ☐ Yes**
If question 6 answered "Yes" (**), the following questions are **required**:	
6a. Housing Move-In Date	_____/_____/_____
6b. Permanent Home Address	
6c. Apartment/Unit #	
6d. City	
6e. State	
6f. Zip	
6g. Monthly rent for this household (inclusive of any rental subsidies)	$_____
Is this a shared housing destination?	☐ No ☐ Yes**
If the question above, "Is this a shared housing destination?" is answered "Yes" (**), the following question is **required**:	
Does the participant share the room they sleep in?	☐ No ☐ Yes

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Outreach *– Outreach projects only, all fields required unless otherwise noted*

7. Has the client been engaged? Engagement means an interactive client relationship results in a deliberate client assessment.	□ No □ Yes: Engagement Date: _____/_____/_____

PATH – *For adults 18 and older and/or Head of Household, all fields required unless otherwise noted, required questions are shaded; Street Outreach and Supportive Services ONLY*

8. PATH status determination completed?	□ No □ Yes** Date of Determination: _____/_____/_____	
If question 8 answered "Yes" (**), the following questions are **required:**		
8a. Was the client determined to be eligible for PATH funded services and enrolled in PATH?	□ No* □ Yes	
If the question above is answered "No" (*), the following question is **required**:		
8b. If not eligible to be enrolled, what is the reason?	□ Client was found ineligible for PATH □ Client was not enrolled for other reason(s)	□ Unable to locate client

COVID-19 Response *– Does the client fall into any of the below categories?*

Individuals who test positive for COVID-19 that do not require hospitalization, but need isolation or quarantine (including those exiting from hospitals).	□ No □ Yes**	
Individuals who have been exposed to COVID-19 (as documented by a state or local public health official, or medical health professional) that do not require hospitalization, but need isolation or quarantine.	□ No □ Yes**	
Individuals who are asymptomatic, but are at "high-risk", such as people over 65 or who have certain underlying health conditions (respiratory, compromised immunities, chronic disease), and who require Emergency NCS as a social distancing measure.	□ No □ Yes**	
If any of the questions above are answered with a "Yes" (**), the following question is **required:**		
Which category does the client fall into? Check all that apply and collect/upload supporting documentation.	□ 65 years of age or older □ Has chronic lung disease or moderate to severe asthma □ People who have serious heart conditions □ People who are immunocompromised (including cancer treatment)	□ People of any age with severe obesity (body mass index [BMI] > 40) or certain underlying medical conditions, particularly if not well controlled, such as those with diabetes, renal failure, or liver disease might also be at risk □ People who are pregnant should be monitored since they are known to be at risk with severe viral illness, however, to date data on COVID-19 has not shown increased risk

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Living Situation *– For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*

9. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	**10. How long was the client staying in that place?** *(Length of stay in prior living situation)*	**10a/b Did the client stay less than…**
Homeless Situations ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter ☐ Safe Haven	***For homeless situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected	**Not Applicable** *Go to question 11*
Institutional Situations ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	***For institutional situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected	***10a: 90 days:*** ☐ Yes *Go to question 10c* ☐ No *Go to question 20*
Temporary Housing Situations ☐ Transitional housing for homeless persons (including homeless youth) ☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Host Home (non-crisis) ☐ Staying or living in a friend's room, apartment or house ☐ Staying or living in a family member's room, apartment or house ***Permanent Housing Situations*** ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with ongoing housing subsidy -Specify Rental Subsidy Type below in 9a ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy	***For temporary & permanent housing situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected	***10b: 7 nights:*** ☐ Yes *Go to question 10c* ☐ No *Go to question 20*
Other ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected		

HMIS Intake and Enrollment Form

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If question #9 was answered as "Rental by client, with ongoing housing subsidy", the following question is **required**:

9a. Rental Subsidy Type:	☐ GPD TIP housing subsidy ☐ VASH housing subsidy ☐ RRH or equivalent subsidy ☐ HCV voucher (tenant or project based) (not dedicated) ☐ Public housing unit ☐ Rental by client, with other ongoing housing subsidy	☐ Housing Stability Voucher ☐ Family Unification Program Voucher (FUP) ☐ Foster Youth to Independence Initiative (FYI) ☐ Permanent Supportive Housing ☐ Other permanent housing dedicated for formerly homeless persons

If the client is coming from an institution after having stayed less than 90 days or if the client is coming from a transitional, permanent, or other situation after having stayed less than 7 nights, then the following question is required:

10c. On the night before your current housing situation, did you stay on the streets, in an emergency shelter, or at a safe haven?	☐ No ☐ Yes**

If the project being entered is an emergency shelter, safe haven, or transitional housing then the following question is required:

10d. Is this your first time homeless?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

If the project being entered is an emergency shelter, safe haven, place not meant for habitation, or interim housing, or client selected "Yes" on question #10c, then the following questions are required.

11. Approximately what date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date homelessness started)*	_____/_____/_____	
12. In the past three years, how many times have you returned to the streets, an emergency shelter, or a safe haven after being housed? *(Number of times on the streets, in ES, or Safe Haven in the past three years including today)*	☐ One time ☐ Two times ☐ Three times ☐ Four or more times	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
12a. IN THE PAST YEAR, including this time, how many separate times have you experienced homelessness, on the street, in a vehicle or in shelters?	☐ None ☐ One time ☐ 2 to 3 times	☐ 4 or more times ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
13. In those three years, what is the total number of months spent homeless on the streets, in an emergency shelter, or in a safe haven? *(Total number of months homeless on the street, in ES, or SH in the past three years)*	☐ One month (this time is the first month) ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months	☐ 7 months ☐ 8 months ☐ 9 months ☐ 10 months ☐ 11 months ☐ 12 months ☐ More than 12 months	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Crisis and Bridge Housing

Please note: All questions shaded in dark gray are REQUIRED. All questions in light gray are SOFT REQUIRED. All questions not shaded at all (white) are not required. All questions answered with a * or ** that are followed by a follow-up questions are REQUIRED as well. Please read all parts of the document fully and thoroughly and follow the instructions. Follow this rule throughout the entire survey.

20. Have you entered and been released from any of the following facilities in the past two months? (Choose all that apply)	☐ Foster care home or foster care group home* ☐ Hospital of other residential psychiatric medical facility * ☐ Jail, prison, or juvenile detention facility* ☐ Long-term care facility or nursing home*	☐ Psychiatric hospital or other psychiatric facility* ☐ Substance abuse treatment facility or detox center* ☐ No, has not exited any of these facilites in the past two months ☐ Client doesn't know ☐ Client prefers not to answer
If question #20 was answered as anything with a (*), then the following questions are **required**:		
20a. Which one have you most recently been released from? (Choose one)	☐ Foster care home or foster care group home* ☐ Hospital of other residential psychiatric medical facility * ☐ Jail, prison, or juvenile detention facility* ☐ Long-term care facility or nursing home*	☐ Psychiatric hospital or other psychiatric facility* ☐ Substance abuse treatment facility or detox center* ☐ No, has not exited any of these facilites in the past two months ☐ Client doesn't know ☐ Client prefers not to answer
20b. Date left	_____/_____/_____	

DPSS Crisis Housing Order Form

☐ TAY	☐ Disabled

Disabling Conditions and Barriers *– For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*

21. Do you have a physical disability?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #21 was answered as "Yes", then the following questions are **required**:		
21a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
22. Have you ever been told you have a learning disability or developmental disability?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
23. Do you have a chronic health condition? *A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to:* ***heart disease*** *(including coronary heart disease, angina, heart attack and any other kind of heart condition or disease);* ***severe asthma****; diabetes;* ***arthritis-related conditions*** *(including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia);* ***adult onset cognitive impairments*** *(including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions);* ***severe headache/migraine****;* ***cancer****;* ***chronic bronchitis****;* ***liver condition; stroke****; or* ***emphysema****.*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #23 was answered as "Yes", then the following questions are **required**:		
23a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
24. Have you been diagnosed with AIDS or have you tested positive for HIV?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
25. Do you feel you currently have a mental health disorder?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #25 was answered as "Yes", then the following questions are **required**:		
25a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
26. Do you *currently* have a drug or alcohol problem?	☐ No ☐ Alcohol ☐ Drug ☐ Both	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #26 was answered as "Alcohol", "Drug", or "Both", then the following questions are **required**:		
26a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Disability Summary *– If the client answered any of the questions in Disabling Conditions and Barriers as "Yes**" (with two **), then the below question should be answered as Yes. Reponses without the two ** are not considered disabling conditions.*

Client has a disabling condition	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

DV and Other History *– For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*

27. Are you a survivor of domestic violence or of intimate partner violence?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #27 was answered as "Yes" (**), then the following question is **required**:		
27a. If you experienced domestic or intimate partner violence, how long ago did you have this experience?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to one year ago (excluding one year exactly) ☐ One year ago or more ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected	
27b. Are you currently fleeing?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
27c. Are you experiencing homelessness because you are currently fleeing domestic violence, dating violence, sexual assault, or stalking? *(ES, SH, TH Program also)*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
28. Have you ever worked or done an illegal act and someone else took some or all of the money? *(Emergency Shelter, Safe Haven, and Transitional Housing Projects only)*	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #28 was answered as "Yes" (**), then the following question is **required**:		
28a. What type of work/illegal act did you have to do?	☐ Agricultural work ☐ Panhandling ☐ Door-to-door sales ☐ Restaurant/catering work ☐ Household/childcare work ☐ Illegal goods sales (drugs, guns, etc.)	☐ Sex work ☐ Other ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Tuberculosis *– Emergency Shelters only, all fields required unless otherwise noted*

29. Do you have a cough that has lasted longer than 3 weeks?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer
30. Have you recently lost weight without explanation during the past month?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer
31. Have you had frequent night sweats during the past month, soaking your sheets or clothing?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer
32. Have you coughed up blood in the past month?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer

33. Have you been feeling much more tired than usual over the past month?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer
34. Have you had fevers almost daily for more than one week?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer

Employment *- For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*

35. Are you currently employed?	☐ No* ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #35 was answered as "No" (*), then the following question is **required**:		
35a. Are you…. *(read options to the right)*	☐ Looking for work ☐ Unable to work	☐ Not looking for work
If question #35 was answered as "Yes" (**), then the following question is **required**:		
35b. What type of employment do you have?	☐ Full-time ☐ Part-time	☐ Seasonal / sporadic (including day labor)

Cash Income for Individual *- For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*

Please note: All questions shaded in dark gray are REQUIRED. All questions in light gray are SOFT REQUIRED. All questions not shaded at all (white) are not required. All questions answered with a * or ** that are followed by a follow-up questions are REQUIRED as well. Please read all parts of the document fully and thoroughly and follow the instructions. Follow this rule throughout the entire survey.

36. Do you receive any cash income?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer	☐ Data not collected
If question #36 was answered as "Yes" (**), then the following questions are **required**:			

Income Source and Monthly Income: *What sources of income do you have, and how much do you get on a monthly basis?*			
☐ Earned Income (employment wages / cash)	$	☐ Temporary Assistance for Needy Families (CalWorks)	$
☐ Unemployment Insurance	$	☐ General Assistance (GA) / General Relief (GR)	$
☐ Supplemental Security Income (SSI)	$	☐ Retirement Income from Social Security	$
☐ Social Security Disability Insurance (SSDI)	$	☐ Pension or retirement income from a former job	$
☐ VA Service-Connected Disability Compensation	$	☐ Child Support	$
☐ VA Non-Service-Connected Disability Pension	$	☐ Alimony and other spousal support	$
☐ Private Disability Insurance	$	☐ Other Source (Specify:_____)	$
☐ Worker's Compensation	$		
Total Monthly Cash Income for Individual	$		

36a. Cash Income Documentation *Do you have documents that verify income?*	☐ GR Form ☐ Pay Stub ☐ Utility Allowance ☐ Child Support Forms ☐ Social Security Forms ☐ SSI Forms	☐ CalWORKs Form ☐ Unemployment Insurance Forms ☐ W-2 Forms ☐ SSDI Form ☐ Workmans Comp ☐ Self Employment Docs	☐ Pension Letter/Stub ☐ Unemployment Forms ☐ Self Declaration ☐ Employer Printout/Letter ☐ VA Documentation ☐ Other (Specify:_____)

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Non-Cash Benefits *- For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*

37. Do you receive any non-cash benefits?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #37 was answered as "Yes" (**), then the following question is **required**:		
Non-Cash Benefits *What non-cash benefits do you receive? (Check all that apply)*	☐ Food Stamps/CalFresh (Supplemental Nutrition Assistance Program, SNAP) ☐ WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) ☐ CalWorks child care services ☐ CalWorks transportation services ☐ Other CalWorks-funded services ☐ Other source (Specify): _____	

Health Insurance *- All clients, all fields required unless otherwise noted*

38. Are you covered by any type of health insurance?	☐ No* ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #38 was answered as "No" (*), then the following questions are **required**:		
Reason	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #38 was answered as "Yes" (**), then the following questions are **required**:		
38a. Health Insurance *(Check all that apply):*	☐ Medi-Cal (MEDICAID) ☐ MEDICARE ☐ State Children's Health Insurance Program (SCHIP) ☐ VA medical services ☐ Employer-provided health insurance ☐ COBRA	☐ Private pay health insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other health insurance (Specify:_____)
38b. Health Insurance Provider	☐ Health Net ☐ Molina ☐ My Health LA (DHS) ☐ Anthem Blue Cross ☐ Kaiser Permanente ☐ VA	☐ L.A. Care ☐ Care 1st Health Plan ☐ SCAN Health Plan ☐ Other ☐ Unknown

Youth/TAY *– For Youth TAY or TAY/RHY Program*

Please note: All questions shaded in dark gray are REQUIRED. All questions in light gray are SOFT REQUIRED. All questions not shaded at all (white) are not required. All questions answered with a * or ** that are followed by a follow-up questions are REQUIRED as well. Please read all parts of the document fully and thoroughly and follow the instructions. Follow this rule throughout the entire survey.

39. Did you run away from home or a foster care home? *(TAY)*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

For ES/SH/Th Program or Youth TAY or TAY/RHY Program			
40. Have you ever been involved in any of the following systems? - *(For ES, SH, TH Program, TAY Youth and RHY)*			
Foster Care		☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
	Number of years in foster care:	☐ Less than one year ☐ 1 to 2 years	☐ 3 to 5 or more years
	Number of months in foster care:	☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐ 7 months ☐ 8 months	☐ 9 months ☐ 10 months ☐ 11 months
Juvenile Justice System		☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
	Number of years in juvenile justice system:	☐ Less than one year ☐ 1 to 2 years	☐ 3 to 5 or more years
	Number of months in juvenile justice system:	☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐ 7 months ☐ 8 months	☐ 9 months ☐ 10 months ☐ 11 months
Mandated stay in inpatient or outpatient mental health treatment facility		☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Jail		☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Prison		☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Adult Probation		☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Parole		☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Sexual Orientation *- For adults 18 and older and/or Head of Household, all fields required unless otherwise noted*		
43. Which of the following best represents how you think about yourself?	☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Questioning/Unsure ☐ Other**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #43 was answered as "Other" (**), then the following question is **required**:		
43a. Please describe:	_____	

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Health and Education *– All clients aged 16 and older; all fields required unless otherwise noted*

44. Are you pregnant?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #44 was answered as "Yes" (**), then the following question is **required**:		
44a. What is your due date?	_____/_____/_____	
45. General Health *(RHY or VASH Program or HoH/Adult aged 18 or older)*	☐ Excellent ☐ Very good ☐ Good ☐ Fair	☐ Poor ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
72. Dental Health Status *(RHY or VASH Program or HoH/Adult aged 18 or older)*	☐ Excellent ☐ Very good ☐ Good ☐ Fair	☐ Poor ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
73. Mental Health Status *(RHY or HoH/Adult aged 18 or older)*	☐ Excellent ☐ Very good ☐ Good ☐ Fair	☐ Poor ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
46. What is the highest education level that you have completed? *(RHY, SSVF, VASH Program or HoH/Adult aged 18 or older)*	☐ Less than grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12 ☐ School program does not have grade levels ☐ GED ☐ Some college	☐ Associates degree ☐ Bachelor's degree ☐ Graduate degree ☐ Vocational certification ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
74. What is your current school status? *(RHY Program or HoH/Adult aged 18 or older)*	☐ Attending school regularly ☐ Attending school irregularly ☐ Graduated from high school ☐ Dropped out ☐ Suspended	☐ Expelled ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
74a. What is your current educational program type?	☐ Highschool/GED ☐ Vocational program ☐ Certificate/license program ☐ Community college	☐ 4- year college/university ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
YHDP: Current school enrollment and attendance	☐ Not currently enrolled in any school or educational course* ☐ Currently enrolled but NOT attending regularly (when school or the course is in session)** ☐ Currently enrolled and attending (when school or the course is in session)**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

If the YHDP question above was answered as "Not currently enrolled" (*), then the following question is **required**:		
YHDP: Most recent education status	☐ K12: Graduated from high school ☐ K12: Obtained GED ☐ K12: Dropped Out ☐ K12: Suspended ☐ K12: Expelled ☐ Higher education: Pursuing a credential but not currently attending ☐ Higher education: Dropped out ☐ Higher education: Obtained a credential/degree	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If the YHDP question above was answered as "Currently enrolled" (**), then the following question is **required**:		
YHDP: Current educational status	☐ Pursuing a high school diploma or GED ☐ Pursuing Associate's Degree ☐ Pursuing Bachelor's Degree ☐ Pursuing Graduate Degree ☐ Pursuing other post-secondary credential	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

SOAR Connection

75. Is the client connected with SOAR? *(PATH, SSVF, or HoH/Adult aged 18 or older)*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Living in or out of Los Angeles County – *Emergency Shelter, Safe Haven, and Transitional Housing projects only.*

47a. Have you ever live outside of LA County?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
47b. How long has it been since you moved or moved back to LA County?	Day(s): _____ Week(s): _____ Month(s): _____ Year(s): _____	
47c. Before the last time you lost your housing, where were you living?	☐ Los Angeles County ☐ Other county in Southern California (Kern, Imperial, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, or Ventura) ☐ Other county in California ☐ Out of state ☐ Outside of the United States ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected	

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Translation Assistance Needed **–** *Head of Household only, all fields required unless otherwise noted*

Is translation assistance needed?	☐ No ☐ Yes**			☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If the question above was answered as "Yes" (**), then the following question is **required**:				
Preferred Language	☐ English ☐ Spanish ☐ Russian ☐ French ☐ Armenian ☐ American Sign Language	☐ Portugese ☐ Chinese ☐ Albanian ☐ Korean ☐ Farsi ☐ Italian ☐ Arabic	☐ German ☐ Vietnamese ☐ Ukrainian ☐ Greek ☐ Polish ☐ Swedish ☐ Japanese	☐ Different Preferred Language** ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If the question above was answered as "Different Preferred Language" (**), then the following question is **required**:				
Specify different preferred language:				

SSVF, VASH, RHY, and HOPWA sections continue on next page.

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**
IBHIS 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 Management Information System (HMIS).

REDISCLOSURE NOTICE:

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

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

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

Purpose of Disclosure:

My PHI may be used for determination of eligibility for the Section 8 Special Program, assistance with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as entering information into the HMIS managed by the Los Angeles Homeless Services Authority. 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 County 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 Housing and Job Development Division Federal Housing Subsidies Unit, 510 S. Vermont Ave., 17th Floor, Los Angeles, CA 90020. 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:

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOUSING AND JOB DEVELOPMENT DIVISION

AFFORDABLE CARE ACT CERTIFICATION FORM

To be completed and signed by the Case Manager:

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

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

Name of Participant: _____

Name of Agency: _____

Print Case Manager's Name: _____

Case Manager's Signature: _____

Date: _____

You can ENROLL in school!

Even if you have:

- **Uncertain housing**
- **A temporary address**
- **No permanent physical address**

You are guaranteed enrollment in school by the federal McKinney-Vento Act and California state law if you live:

- In a shelter (family, domestic violence, or youth shelter or transitional living program)
- In a motel, hotel, or weekly rate housing
- In a house or apartment with more than one family because of economic hardship or loss
- In an abandoned building, in a car, at a campground, or on the street
- In temporary foster care or with an adult who is not your parent or guardian
- In substandard housing (without electricity, water, or heat)
- With friends or family because you are a runaway or an unaccompanied youth

To enroll in or attend school if you live under any of these conditions, you do NOT need to provide:

- Proof of residency
- Immunization records or tuberculosis skin-test results
- School records
- Legal guardianship papers

You may:

- Participate fully in all school activities and programs for which you are eligible.
- Continue to attend the school in which you were last enrolled even if you have moved away from that school's attendance zone or district.
- Receive transportation from your current residence back to your school of origin.
- Qualify automatically for child nutrition programs (free and reduced-price lunches and other district food programs).
- Contact the district liaison to resolve any disputes that arise during the enrollment process.

Parents' responsibilities are to:

- Make sure your child attends school regularly and completes homework and projects on time.
- Attend parent/teacher conferences, Back-to-School Nights, and other school-related activities.
- Stay informed of school rules, regulations, and activities.
- Participate in school advisory/decision-making activities.

For questions about enrolling in school or for assistance with school enrollment, contact:

Your local school district liaison:

Nancy Gutierrez
Pupil Service and Attendance Coordinator
LAUSD Homeless Education Program,
Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012
Phone: 1-213-202-7581

Your county liaison for the homeless:

Melissa Schoonmaker
Homeless Education Program Manager
School Attendance Review Board /
McKinney-Vento
12830 Columbia Way, ECW-3236
Downey, CA 90242
Phone: 1-562-922-6233

Your state coordinator for the homeless:

Leanne Wheeler
State Coordinator
California Department of Education
1430 N Street, Suite 6208
Sacramento, California 95814
Phone: 1-866-856-8214

California Department of Education

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

NOTICE TO HOUSEHOLDS WITH SCHOOL-AGE YOUTH
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

- Go to school, even if they do not have a permanent address
- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
- Have access to the same services and programs that are available to all other students
- Receive transportation to school from their current residence
- Automatically be enrolled in free lunch or free meal programs

The following resources can assist you to access educational benefits for your family:

Los Angeles County Office of Education Website:

http://www.lacoe.edu/StudentServices/HomelessFosterYouth/HomelessChildren

Los Angeles County Office of Education Contact

Melissa Schoonmaker
School Attendance Review Board/McKinney-Vento Homeless Education Program Manager
Email: homeless_program@lacoe.edu
Phone: (562) 922-6233 Fax: (562) 922-6781
Student Support Services - Education Center West (formerly Clark)
12830 Columbia Way, ECW-3236, Downey, CA 90242

Los Angeles Unified School District (LAUSD):

LAUSD Web site

http://homelesseducation.lausd.net/

LAUSD Contact

Angela Chandler, Pupil Service and Attendance Coordinator
Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

ACKNOWLEDGEMENT OF RECEIPT
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

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LAUSD Web site
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LAUSD Contact
Angela Chandler, Pupil Service and Attendance Coordinator
Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

I acknowledge receiving this notice and the attached bulletin: _____
Print Name

_____ _____
Signature Date

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
FEDERAL HOUSING SUBSIDIES UNIT

Sample Format for Case Manager / Housing Liaison Referral Letter

Must be on Agency letterhead.

First Paragraph

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

Troubleshooting

- If exit date at shelter has passed, then explain why the Applicant is still in the program.
- *Example*: "Even though Mr. Smith's residential time at XYZ Shelter has expired, we received permission to allow him to stay here until he is approved for a Continuum of Care Certificate. "
- Be mindful if you allow an Applicant to stay at your facility past their expiration date (i.e., identify why and for how long).

Second Paragraph

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

- Identify and explain **all** Applicant telephone numbers and addresses disclosed **anywhere** in the application package, including the address on the Applicant's CDL or other photo ID.
- Explain why Applicant cannot live at / return to these addresses

Third Paragraph

- Explain why you think this Applicant meets target population for Continuum of Care (Remember: the Applicant has to require a high level of service enough to meet the service match).
- Mental illness should only be mentioned; do not indicate client's diagnosis (e.g., "Mr. Burnett has a mental illness, attends all appointments regularly at the clinic, and is medication compliant.")
- Explain your Applicant's experience with your program
- Always include strengths and positive points concerning the applicant
- Mention Independent Living Skills, especially money management. (Place the person you have chosen for a Continuum of Care Certificate into a Community Living Program or Independent Living Skills class.)

Fourth Paragraph

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

Fifth Paragraph

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

Salutation,

Signature
Title

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

SAMPLE REFERRAL LETTER

November 1, 2020

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

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

Los Angeles County Development Authority:

I am writing this letter in support of Jane Doe's Continuum of Care application. Jane has been a client of the ACTION program since October 18, 2015. ACTION is an assertive community treatment program that assists dually diagnosed consumers with psychotherapy, case management, and psychiatry. Jane has a mental illness and has maintained all scheduled appointments with me for counseling and sees her psychiatrist regularly despite her lack of a fixed nightly residence.

Jane became homeless on January 8, 2016 after fleeing from a domestic violence situation. For the past four years, Jane has lived in inpatient psychiatric hospitals, on the street, crisis residential facilities, LAHSA cold/wet weather shelters, and a garage. We recently met and reviewed her psychiatric treatment history and compiled the following list of dates and locations of Jane's living arrangements. Because of the client's cognitive deficits and memory loss, the following represents the best history this client can recollect:

01/08/2017 to 02/07/2017:	1736 Crisis House, Torrance, CA 90000
02/08/2017 to 03/15/2017:	New Image Emergency Shelter, Los Angeles, CA 90000
03/16/2017 to 06/31/2017:	Shady Lady Motel, 3434 Sunset Blvd., Hollywood, CA 90000
07/01/2017 to 08/31/2017:	Client does not remember where she resided
09/01/2017 to 10/25/2017:	Twin Towers Correctional Facility
10/26/2017 to 12/15/2017:	"Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
12/16/2017 to 12/19/2017:	BHC Hospital, Psychiatric Unit, Rosemead, CA 90000
12/20/2017 to 01/19/2018:	Excelsior House Crisis Residential Treatment, LA, CA 90000
01/20/2018 to 04/01/2018:	"Streets" – Car parked at 1720 E 120th St., Los Angeles, CA 90000 (Car was towed)
04/02/2018 to 04/15/2018:	"Streets" – Alley between Augustus Hawkins MHC and King Drew Medical Center, Los Angeles, CA 90000
04/16/2018 to 06/20/2018:	Help is on the Way Shelter, Los Angeles, CA 90000
06/21/2018 to 07/26/2018:	Client does not remember where she resided

07/27/2018 to 08/05/2018:	Brotman Medical Center, Psychiatric Unit, LA, CA 90000
08/06/2018 to 12/15/2018:	"Streets" – 2nd and Broadway, Santa Monica, CA 90000
12/16/2018 to 03/15/2019:	New Directions Emergency Shelter, West LA, CA 90000
03/16/2019 to 04/10/2019:	Weingart Center Shelter, Los Angeles, CA 90000
04/11/2019 to 08/04/2019:	"Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
08/05/2019 to 08/08/2019:	Robert F. Kennedy, Psychiatric Unit, Los Angeles, CA 90000
08/09/2019 to 02/09/2020:	Daybreak Transitional Living Program, SM, CA 90000
02/10/2020 to 05/06/2020:	Garage/Abandoned Home -- 1796 Raymond St., Los Angeles, CA 90000. The garage lacked cooking facilities, a restroom or shower, running water, electricity, and insulation to keep warm. The roof often leaked when it rains.
05/07/2020 to 05/22/2020:	Twin Towers Correctional Facility – Arrested for trespassing
05/23/2020 to 06/15/2020:	"Streets" – near Cherokee and Hollywood Blvd., Hollywood, CA 90000
06/15/2020 to 09/15/2020:	Jan Clayton Center Residential Substance Abuse Treatment, Hollywood, CA 90000
09/16/2020 to present:	PATH Specialized Shelter Bed Program, LA, CA 90000

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

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

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

Sincerely,
Daisy Obetsanov, MSW
Psychiatric Social Worker