LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE DIRECTOR – COMMUNITY STAKEHOLDER ENGAGEMENT

**ATTACHMENT #1**

# COUNTYWIDE ACTIVITY FUND (CAF) APPLICATION

**Complete and submit your application to the facilitator at the end of today's orientation. Please note that incomplete applications will delay the review process.**

☐ **New Participant** ☐ **Returning Participant**

Name:______________________________________________

Last 4# of Social Security Number:____________________ Vendor ID#:____________________ (If applicable)

Address:______________________________________________

City:____________________ State:____________________ Zip Code:______________

Date of Birth:______________ Phone Number:______________ What Service Area do you live in? ______

Email Address:____________________________ Preferred Language: ____________________

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**How do you identify? Please select one that applies to you:**

☐ Client/Consumer ☐ Caregiver ☐ Family Member (relationship to client):____________________

**Additionally, are you a:** ☐ W.O.W. (Wellness Outreach Worker) ☐ Service Extender

Do you have a Volunteer (Green) Badge? ☐ Yes ☐ No

If yes, please provide Badge # ______________ Expiration Date: ______________

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*I acknowledge that I have read, understand, and agree to the provisions of the CAF Participant On-boarding Protocol and verify the information provided in this application is true and correct.*

| ____________________ | ____________________ | ____________ |
| --- | --- | --- |
| Applicant – Print Name | Applicant Signature | Date |

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*To be completed by MHSA Administration & Oversight Division*

| ____________________ | ____________________ | ____________ |
| --- | --- | --- |
| DMH Approver - Print Name | DMH Approver – Signature | Date |

Please submit your application and any questions to

CAF@dmh.lacounty.gov