



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HOUSING ASSISTANCE PROGRAM - UNIVERSAL APPLICATION

INSTRUCTIONS FOR COMPLETING FORMS

HOUSING ASSISTANCE PROGRAMS CHECKLIST (pg. 2)

This checklist will identify all required documentation that must be submitted when applying for any housing assistance component.

- ◆ Use this checklist to ensure you have included all the required documents.

REQUEST FOR ASSISTANCE FORM (pg. 3)

This form must be completed when applying for any housing assistance program.

- ◆ Check the program where the applicant is currently receiving services or check “other” and include the name of the program.
- ◆ Check the type of housing assistance requested. If applying for more than one program, check all that apply.
- ◆ Check if the applicant is a recipient of a tenant-based subsidy, MHSA project-based housing, Market Rate Apartment or Other and indicate the other type of housing.
- ◆ Check if the applicant was released from a correctional facility.
- ◆ Check if the applicant is on Parole or Probation.
- ◆ Complete applicant and agency information.
- ◆ Must be signed by Applicant, Case Manager and Program Manager.

INCOME STATUS, FAMILY COMPOSITION and EVICTION PREVENTION FORM (pg. 4)

The top portion of the form must be completed when applying for any housing assistance program.

- ◆ Complete family composition, income status, location of most recent homeless episode sections, by checking all that apply.
- ◆ Only complete Eviction Prevention Section when applying for Eviction Prevention.

HOUSEHOLD GOODS AND/OR UTILITY DEPOSIT REQUEST FORM (pg. 5)

Complete these forms when applying for Household Goods and/or Utility Deposit

- ◆ Check type of utility being requested, if applying for more than one utility deposit, check all that apply.
- ◆ Complete vendor's name, amount requested, and itemized cost.
- ◆ When applying for Household Goods list the requested items and attach merchant's invoice.
- ◆ When requesting assistance with utilities' security deposits and turning on fees, attach utility bill.
- ◆ Must be signed by Case Manager and Program Manager.

TEMPORARY RENTAL ASSISTANCE AGREEMENT FORM (pg. 6)

This form is only applicable for DMH Directly-Operated FSP Programs applying for temporary rental assistance.

- ◆ Complete month(s) of rental assistance being requested, and the regular monthly rent amount.
- ◆ Complete housing plan section.
- ◆ Must be signed by Applicant, Case Manager and Program Manager.

LANDLORD VERIFICATION FORM (pg. 7)

This form must be completed by Landlord when applicant is applying for Security Deposit, Eviction Prevention, and/or Temporary Rental Assistance.

- ◆ Present to Landlord for completion along with W-9 form.
- ◆ Must be signed by Applicant and Landlord.

PATH PROGRAM INDIVIDUALIZED HOUSING PLAN (pg. 8)

This form must be completed when applying for any housing assistance component.

- ◆ Check the appropriate strategy, target date and accomplished date for each of the three goals.
- ◆ Must be signed by the applicant and the case manager.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HMIS

This form must be completed when applying for any housing assistance program.

- ◆ Must be signed and dated by the applicant / personal representative.

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

This form must be completed when applying for any housing assistance program.

- ◆ Must be signed and dated by the applicant / personal representative. The application cannot be submitted to Brilliant Corners without this signed form.

PATH SUPPLEMENTAL INFORMATION FORM

This form must be completed when applying for any housing assistance program.

- ◆ Must be signed and dated by the agency staff. Completing these data elements is a requirement of the funding source. DMH Housing and Job Development Division staff will enter the data into HMIS.

AGENCY VERIFICATION OF HOMELESSNESS

This form must be completed when applying for Security Deposit, Utility Deposit, and Household Goods.

- ◆ Must be completed by the referring agency and signed by Case Manager and Program Manager.

CERTIFICATION OF RESIDENCE IN A HOMELESS FACILITY

This form must be completed when applying for Security Deposit, Utility Deposit, and Household Goods.

- ◆ Must be completed and signed by the homeless facility staff member.

HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION
CHECKLIST

REQUIRED DOCUMENTS FOR ANY HOUSING ASSISTANCE PROGRAM REQUEST

- ☐ If the applicant is a recipient of a **Tenant Based or Project Based** Subsidy,
 - applicant does not need to provide documents for minors;
 - applicant can submit homelessness document from Housing Authority application.
- ☐ Photo Identification of applicant and all household members 18 years of age and older.
- ☐ Verification of having a financial need by case manager.
- ☐ Authorization For Use/Disclosure of Protected Health Information for HMIS
- ☐ HAP HMIS Supplemental Information Form
- ☐ W-9 Form completed by the Vendor/property owner/property management agency
- ☐ Authorization For Use/Disclosure of Protected Health Information for Brilliant Corners
- ☐ Agency Verification of Homelessness (*not used for Eviction Prevention*)
- ☐ Certification of Residence in a Homeless Facility (*not used for Eviction Prevention*)
- ☐ Individualized Housing Plan

ADDITIONAL REQUIRED DOCUMENTS FOR SECURITY DEPOSIT

- ☐ If the applicant is a recipient of a **Tenant Based Subsidy such as Housing Choice Voucher or Continuum of Care**, attach one of the following items which stipulate the applicant and Housing Authority's shares of the rent and a statement that the unit has been inspected and approved.
 - ☐ **Letter of Determination*** from the Housing Authority of the City of Los Angeles, or;
 - ☐ Verification of **Lease Approval*** from the Los Angeles County Development Authority
- ☐ If the applicant is **NOT** a **Tenant Based Subsidy** recipient, a signed copy of the Lease Agreement.

ADDITIONAL REQUIRED DOCUMENTS FOR EVICTION PREVENTION

- ☐ Evidence that the applicant has resided in the unit for at least 6 months (lease agreement).
- ☐ Proof of Applicant's current income (i.e., payroll stubs, verification of receipt of SSI, SSDI or SDI Benefits).

ADDITIONAL REQUIRED DOCUMENTS FOR HOUSEHOLD GOODS

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

ADDITIONAL REQUIRED DOCUMENTS FOR UTILITY ASSISTANCE

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

- ☐ Utility bill from the relevant utility company(s).
- ☐ Signed copy of the Lease Agreement.

**ADDITIONAL REQUIRED DOCUMENTS FOR ANY DIRECTLY OPERATED FSP CLIENT
APPLYING FOR TEMPORARY RENTAL ASSISTANCE**

- ☐ Signed Rental Assistance Agreement Form.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HOUSING ASSISTANCE PROGRAMS – UNIVERSAL APPLICATION

REQUEST FOR ASSISTANCE FORM

Please check all that apply:

Applicant is currently enrolled in: ☐ HOME ☐ PEI ☐ FSP ☐ Outpatient Care Services ☐ PATH ☐ Other _____

Type of assistance applicant is applying for:

☐ Security Deposit ☐ Eviction Prevention ☐ Temporary Rental Assistance **(DMH Directly-Operated FSP only)**

☐ Household Goods ☐ Utility Assistance ☐ PHAP

Is applicant a recipient of: ☐ Tenant Based Subsidy (Housing Choice Voucher/Continuum of Care) ☐ MHSA Project Based ☐ Market Rate Apartment ☐ Other Housing _____

Was applicant released from a correctional facility within the last 12 months ☐ Yes ☐ No

Is applicant currently on ☐ Parole or ☐ Probation

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

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

Current Address: _____ City: _____ Zip: _____

IBHIS #: _____ SSN: _____ DOB: _____

Agency Name: _____

Address: _____ City: _____ Zip: _____

Case Manager: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

The agency declares and certifies each of the following statements to be true and correct:

1. The agency is currently providing mental health services and case management to the applicant and has verified the income and identification of all members of the applicant's household.
2. The agency has provided information to the applicant on tenant-landlord rights and tenant responsibilities, including the appropriate treatment of rental property, appropriate behavior within the neighborhood, and the importance of timely payment of rent.
3. The applicant is eligible to participate in this program and has a documented income source that can reasonably be expected to cover the proposed rent and living expenses.

Applicant: _____
Signature Date

Case Manager: _____
Signature Date

Program Manager _____
Print Name Date

Program Manager: _____
Signature Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOUSING ASSISTANCE PROGRAMS – UNIVERSAL APPLICATION
INCOME STATUS / FAMILY COMPOSITION / EVICTION PREVENTION REQUEST FORM

INCOME STATUS	
<p>What is the applicant's total monthly income? \$ _____ Total monthly expenses? \$ _____</p> <p>Indicate the source(s) of income on the HMIS Intake and Enrollment Form, page 2.</p>	
FAMILY COMPOSITION	
<p>Family Type:</p> <p><input type="checkbox"/> Single Adult</p> <p><input type="checkbox"/> Adult w / child</p> <p><input type="checkbox"/> Adult w / children</p> <p><input type="checkbox"/> Two Adults</p> <p><input type="checkbox"/> Two Adults w / child</p> <p><input type="checkbox"/> Two Adults w / children</p>	<p>Number of Children</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5 or more</p>
<p>Give a brief description of why the applicant needs housing assistance:</p> 	

Location of the applicant's most recent episode of homelessness:	
<p><input type="checkbox"/> SA 1 Antelope Valley</p> <p><input type="checkbox"/> SA 2 San Fernando Valley</p> <p><input type="checkbox"/> SA 3 San Gabriel Valley</p> <p><input type="checkbox"/> SA 4 Metro LA</p>	<p><input type="checkbox"/> SA 5 West LA</p> <p><input type="checkbox"/> SA 6 South LA</p> <p><input type="checkbox"/> SA 7 South East</p> <p><input type="checkbox"/> SA 8 Harbor</p>
EVICTION PREVENTION REQUEST	
<p>(Only complete if applying for eviction prevention funding)</p>	
<p>Monthly rent \$ _____</p> <p>How many months has the applicant lived at the present address? _____ Months</p> <p>Amount behind in rent:</p> <p>\$ _____</p> <p style="color: red;"><i>Note: The payment of rent in arrears cannot exceed one month's rent plus a reasonable documented late charge.</i></p> <p>Is the client in imminent risk of losing his/her housing within the next 14 days? YES ___ NO ___</p> <p>Has the applicant received one of the following? <i>(Please state date notice was received)</i></p> <p><input type="checkbox"/> 3 Day Notice to Pay or Quit (Date: _____)</p> <p><input type="checkbox"/> 5 day Marshall Notice to Vacate (Date: _____)</p> <p><input type="checkbox"/> 30 day Notice (Date: _____)</p> <p><input type="checkbox"/> Unfavorable Court Judgment (Date: _____)</p>	



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION



TEMPORARY RENTAL ASSISTANCE REQUEST FORM
(DMH Directly-Operated FSP ONLY)

As a condition of the Full Service Partnership Temporary Rental Assistance Program, I agree to have the County of Los Angeles Department of Mental Health issue a check payable to my landlord each month up to 6 months with opportunities for extensions as approved. This rental assistance payment will be in the amount of \$....., for each of the months that I am eligible. In addition, I agree to disclose information related to eligibility for Federal Subsidies to inform the program administrators of the appropriate funding sources for the Temporary Rental Assistance Program and/or housing strategies to pursue permanent housing.

I agree to:

- ❖ Work with my Case Manager to (1) find other housing options, if needed, (2) participate in establishing income benefits to continue rental payments after the subsidy is terminated and, (3) assume responsibility of my entire monthly rent.
- ❖ Immediately notify my Case Manager of any changes in rent amount or housing composition (including receipt of any other subsidized housing, such as Continuum of Care, Housing Choice Voucher, Time Limited Subsidies or any other rent contributions program), but not later than 3 business days after the change occurs.

I understand that the rental assistance payments are temporary housing assistance issued to eligible FSP individuals and their families. I also understand that should my FSP services be discontinued within this agreement period, the rental assistance will be discontinued. T

Housing Plan: _____

TEMPORARY RENTAL ASSISTANCE

Type of housing for which you are requesting a subsidy:

- | | |
|--|---|
| <input type="checkbox"/> Sober Living Home | <input type="checkbox"/> Transitional Housing |
| <input type="checkbox"/> Shared/Collaborative Housing | <input type="checkbox"/> Apartment |
| <input type="checkbox"/> Residential Treatment Program | <input type="checkbox"/> Other _____ |

Requested length of subsidy in months: _____

I, _____, (*Applicant's Name*) accept rental assistance payments and agree to the terms indicated above. I also understand that although DMH is making a partial or full payment of rent, the County is in no way a party to the rental agreement I have with the landlord.

Applicant's Name (Print)

Address, City & Zip

Applicant's Signature

(_____) _____

Telephone

Date

Case Manager

Date

Program Manager

Date

COUNTY OF LOS ANGELES



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

LANDLORD VERIFICATION FORM
(To be completed by Landlord)

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

The property is located at _____
Street Address *Apt. #*

_____ *City* _____ *Zip Code*

Type of Request:

☐ **Security Deposit** ☐ **Temporary Rental Assistance** (Directly-Operated FSP ONLY) ☐ **Eviction Prevention**

<p>Complete if applying for Security Deposit and/or Temporary Rental Assistance.</p> <p>Security deposit amount: \$ _____</p> <p>Regular month's rent: \$ _____</p> <p>Tenant's rent portion: \$ _____</p>	<p>Complete if applying for Eviction Prevention.</p> <p>Rent: \$ _____</p> <p>Late charges (as stated in lease): \$ _____</p> <p>Tenant's rent portion: \$ _____</p>
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Apartment/House is: ☐ **Furnished** ☐ **Unfurnished**

Rent Includes: ☐ **Electricity** ☐ **Water** ☐ **Gas** ☐ **Trash**

Date Tenancy Began/Will Begin: _____ / _____ / _____

Make checks payable to: _____
(Checks to be made only to the property owners or authorized Management Company)

Name of Property Owner: _____

Address: _____

Telephone Number: (____) _____ / **e-mail address** _____

Property Owner Signature: _____ **Date:** _____ / _____ / _____
(or designee)

I understand that this is a Federal and/or State funded program and that abuse of this program is an offense. I certify under penalty of jury that all information that I have provided on this form is true and correct.

Applicant's Signature: _____ **Date:** _____ / _____ / _____

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

DO NOT WRITE IN THIS BOX (For Office Use Only)	
<p>Amount Approved for payment: \$ _____</p> <p>By: _____</p>	<p>Initialed</p>

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HOUSING AND JOB DEVELOPMENT DIVISION



Individualized Housing Plan

Applicant Name _____

Date Completed _____

Using Client's own words, identified Long-Term Housing Goal:				
Goals	Strategies	Responsibility (Applicant/Case Manager)	Target Date	Accomplished Date
Goal #1 To locate affordable housing	<u>Types of Housing:</u> <input type="checkbox"/> Project Based Housing with subsidy <input type="checkbox"/> Continuum of Care Certificate <input type="checkbox"/> Section 8 Voucher <input type="checkbox"/> Adult Residential Facility <input type="checkbox"/> Non-subsidized Apartment/Room/House <input type="checkbox"/> Other _____	Case Manager and Client		
Goal #2 To access financial resources for housing	<u>Apply for PATH funds:</u> <input type="checkbox"/> Move-In Assistance <input type="checkbox"/> Eviction Prevention <input type="checkbox"/> Household Goods Assistance <input type="checkbox"/> Utilities Assistance	Case Manager, Applicant and HAP program		
Goal #3 Participate in mental health and other supportive services in order to retain permanent housing	Participate in on-going mental health services including: <input type="checkbox"/> Psychiatric Services <input type="checkbox"/> Medication Support <input type="checkbox"/> Case Management <input type="checkbox"/> Individual and Group Therapy <input type="checkbox"/> Employment/Educ./Voc. Services <input type="checkbox"/> Substance Use Treatment	Case Manager and Applicant		

Client Signature

Date

Case Manager's Signature

Date

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

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

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

CLIENT/INDIVIDUAL IDENTIFICATION

First Name

Last Name

Street Address

City, State, Zip

()

IS Number

Birth Date

Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

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

REDISCLASURE NOTICE:

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

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Used, Received and/or Disclosed:

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

Purpose of Disclosure:

My PHI may be used to coordinate services and comply with P.A.T.H. grant reporting and outcome data requirements.

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

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

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

NOTICE

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

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

EXPIRATION DATE

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

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

Signature of Client/Individual/Personal Representative

Date

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

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

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative

Date

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

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

CLIENT:

Name of Client/Previous Name	Birth Date	Client Number
Name of Legal Representative (If applicable)		
Street Address	City, State ZIP Code	

AUTHORIZES:

**USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO:**

Name of Agency	Name of Health Care Provider/Other
Street Address	Street Address
City, State ZIP Code	City, State ZIP Code

INFORMATION TO BE RELEASED:

☐ Assessment/Evaluation ☐ Psychological Test Results ☐ Diagnosis
☐ Laboratory Results ☐ Medication History/Current Medication ☐ Treatment
☐ Entire Record (Justify): _____
☐ Other (Specify): _____

NOTE: Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested.

Check all that apply: ☐ Alcohol or Drug Records ☐ HIV Test Results

Method of delivery of requested records:

☐ Mail ☐ Pickup ☐ Electronic Device (CD, USB)

PURPOSE OF USE OR DISCLOSURE: (Check applicable category)

☐ Client Request
☐ Other (Specify): _____

Will the agency receive any benefits for the use or disclosure of information? ☐ Yes ☐ No

I understand that my Protected Health Information 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 used or disclosed, it may not be possible to recall.

EXPIRATION DATE: This Authorization is valid until ____ / ____ / ____.
Month Day Year

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of 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.

Right to Revoke Authorization - I understand that I have the right to revoke this Authorization at any time by notifying LACDMH in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to:

Contact Person

Agency Name

Address

City, State ZIP Code

I also understand that a revocation will not affect the ability of LACDMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization or otherwise allowed by law.

Conditions: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, LACDMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this Authorization is related to research that includes treatment, you will not receive that treatment unless this Authorization form is signed.)

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/Legal Representative

Date

If signed by someone other than the client, state relationship and authority:

REVOCATION OF AUTHORIZATION

Name of Client

Signature of Client/Legal Representative

Date

If signed by someone other than the client, print name and state relationship and authority.

Printed Name: _____

Relationship and Authority: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HOUSING AND JOB DEVELOPMENT DIVISION

AGENCY VERIFICATION OF HOMELESSNESS

CHECK THE APPROPRIATE BOXES UNDER HOMELESS OR CHRONICALLY HOMELESS

I certify that _____ is
(Name of Applicant)

☐ **HOMELESS**

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

OR

☐ **CHRONICALLY HOMELESS**

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

Referring Agency Name: _____

Address: _____

Case Manager's Name/Signature _____

Date: _____ Telephone Number: _____

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

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
HOUSING AND JOB DEVELOPMENT DIVISION

HOUSING ASSISTANCE PROGRAM

CERTIFICATION OF RESIDENCE IN A HOMELESS FACILITY

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

(Signature) Date

CERTIFICATION

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

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

from _____ to _____.

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

Title: _____ Telephone: _____

Facility: _____
(Name and address of facility)

Type of Facility:

- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Institution
- ☐ Residential Care Facility
- ☐ Other - Specify _____

Request for Taxpayer Identification Number and Certification

► Go to www.irs.gov/FormW9 for instructions and the latest information.

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

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ► _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <small>(Applies to accounts maintained outside the U.S.)</small>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6 City, state, and ZIP code		
7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
				-				-	
or									
Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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

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

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting*, later, for further information.

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

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*).

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the instructions for Part II for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships*, earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

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

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

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

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

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

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

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

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

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

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.SSA.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/Businesses and clicking on Employer Identification Number (EIN) under Starting a Business. Go to www.irs.gov/Forms to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to www.irs.gov/OrderForms to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

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

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

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

Part II. Certification

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

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

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

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

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

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

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

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

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor ²
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
6. Sole proprietorship or disregarded entity owned by an individual	The owner ³
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor ⁴

For this type of account:	Give name and EIN of:
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity ⁴
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee

For this type of account:	Give name and EIN of:
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

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

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

³ You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

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

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the FTC at www.ftc.gov/idtheft or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see www.IdentityTheft.gov and Pub. 5027.

Visit www.irs.gov/IdentityTheft to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

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

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Polish	<input type="checkbox"/> Portugese <input type="checkbox"/> Russian <input type="checkbox"/> Swedish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (specify: _____) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
TB Clearance Date	____ / ____ / ____	Clinic: _____
DPSS ID	_____	
ILP eligibility confirmed? (to be completed by SPA matcher.)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Undetermined
DMH eligibility confirmed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Undetermined
Reviewed for COVID-19 vulnerability and Project Room Key?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Potentially eligible	<input type="checkbox"/> N/A (housed) <input type="checkbox"/> Missing key data/client follow up necessary
Veteran Status	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Don't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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:		
Dates of military service (Year Only)	_____ to _____	
Veteran Health Administration (VHA) Eligible	<input type="checkbox"/> No <input type="checkbox"/> Yes	
VASH Status	<input type="checkbox"/> Admitted <input type="checkbox"/> Ineligible background (not eligible because of criminal background) <input type="checkbox"/> Ineligible case management (ineligible because they currently do not need that level of case management)	
	<input type="checkbox"/> Ineligible Veteran Health Administration (VHA) (ineligible because they are not VA healthcare eligible) <input type="checkbox"/> Interested list <input type="checkbox"/> Needs screening	<input type="checkbox"/> Vouchered <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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	<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> LAHSA Funded Access Center <input type="checkbox"/> LAHSA Funded Housing Navigation Program <input type="checkbox"/> LAHSA Funded Interim Housing (Bridge) <input type="checkbox"/> LAHSA Funded Interim Housing (Crisis) <input type="checkbox"/> LAHSA Funded Interim Housing (Host Home) <input type="checkbox"/> LAHSA Funded Street Outreach Program <input type="checkbox"/> DHS Funded Countywide Benefits Entitlement Services Team (CBEST) <input type="checkbox"/> DHS Funded E6 Multi-Disciplinary Outreach Team <input type="checkbox"/> DHS Funded Interim Housing </div> <div style="width: 48%;"> <input type="checkbox"/> DHS Funded Interim Housing Intensive Case Management (ICMS) Program <input type="checkbox"/> DMH Funded Full Service Partnership Program <input type="checkbox"/> DMH Funded Housing Specialist and Housing Liaisons <input type="checkbox"/> DMH Funded Interim Housing <input type="checkbox"/> DMH Funded Recovery Resilience and Reintegration Services <input type="checkbox"/> DPH Funded Substance Use Disorder Case Manager <input type="checkbox"/> Other (specify: _____) </div> </div>	

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:

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Client Contact Information (Location)

Address Type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Mailing <input type="checkbox"/> Emergency <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Spouse <input type="checkbox"/> Temporary <input type="checkbox"/> Other <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Message <input type="checkbox"/> Management Compancy <input type="checkbox"/> Forwarding Address	Name	
	Address 1	
	Address 2	
	City	
	State	
	Zip Code	
	Email	
	Phone 1	
	Phone 2	

Current Living Situation (Location)

Address Type: <input type="checkbox"/> 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	<input type="checkbox"/> Self (head of household) <input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> Head of household's child <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Head of household's spouse or partner
4. Enrollment CoC	<input type="checkbox"/> CA-600 – Los Angeles <input type="checkbox"/> CA-607 – Pasadena <input type="checkbox"/> CA-614 – San Luis Obispo County <input type="checkbox"/> CA-602 – Orange County <input type="checkbox"/> CA-611 – Ventura County <input type="checkbox"/> CA-606 – Long Beach <input type="checkbox"/> CA-612 – Glendale

CES Placement – Permanent Housing and Transitional Housing only

5. Was the client placed into this housing program through CES?	<input type="checkbox"/> No <input type="checkbox"/> CES for Single Adults <input type="checkbox"/> CES for Families <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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.	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No* <input type="checkbox"/> Yes
If the question above is answered "No" (*), the following question is required :	
8b. If not eligible to be enrolled, what is the reason?	<input type="checkbox"/> Client was found ineligible for PATH <input type="checkbox"/> Client was not enrolled for other reason(s) <input type="checkbox"/> 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).	<input type="checkbox"/> No <input type="checkbox"/> 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.	<input type="checkbox"/> No <input type="checkbox"/> 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.	<input type="checkbox"/> No <input type="checkbox"/> 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.	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> 65 years of age or older <input type="checkbox"/> Has chronic lung disease or moderate to severe asthma <input type="checkbox"/> People who have serious heart conditions <input type="checkbox"/> People who are immunocompromised (including cancer treatment) </div> <div style="width: 50%;"> <input type="checkbox"/> 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 <input type="checkbox"/> 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 </div> </div>

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 <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter <input type="checkbox"/> Safe Haven 	For homeless situations: <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected 	Not Applicable Go to question 11
Institutional Situations <ul style="list-style-type: none"> <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center 	For institutional situations: <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected 	10a: 90 days: <ul style="list-style-type: none"> <input type="checkbox"/> Yes Go to question 10c <input type="checkbox"/> No Go to question 20
Temporary Housing Situations <ul style="list-style-type: none"> <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house 	For temporary & permanent housing situations: <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected 	10b: 7 nights: <ul style="list-style-type: none"> <input type="checkbox"/> Yes Go to question 10c <input type="checkbox"/> No Go to question 20
Permanent Housing Situations <ul style="list-style-type: none"> <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy -Specify Rental Subsidy Type below in 9a <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy 		
Other <ul style="list-style-type: none"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected 		

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

9a. Rental Subsidy Type:

- | | |
|--|--|
| <input type="checkbox"/> GPD TIP housing subsidy | <input type="checkbox"/> Housing Stability Voucher |
| <input type="checkbox"/> VASH housing subsidy | <input type="checkbox"/> Family Unification Program Voucher (FUP) |
| <input type="checkbox"/> RRH or equivalent subsidy | <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) |
| <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) | <input type="checkbox"/> Permanent Supportive Housing |
| <input type="checkbox"/> Public housing unit | <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons |
| <input type="checkbox"/> Rental by client, with other ongoing housing subsidy | |

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 ☐ Client doesn't know
☐ Yes ☐ 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)	<input type="checkbox"/> One time <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Two times <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Three times <input type="checkbox"/> Data not collected <input type="checkbox"/> Four or more times	
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?	<input type="checkbox"/> None <input type="checkbox"/> 4 or more times <input type="checkbox"/> One time <input type="checkbox"/> Client doesn't know <input type="checkbox"/> 2 to 3 times <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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)	<input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 7 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> 2 months <input type="checkbox"/> 8 months <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 3 months <input type="checkbox"/> 9 months <input type="checkbox"/> Data not collected <input type="checkbox"/> 4 months <input type="checkbox"/> 10 months <input type="checkbox"/> 5 months <input type="checkbox"/> 11 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> More than 12 months	

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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)	<input type="checkbox"/> Foster care home or foster care group home* <input type="checkbox"/> Hospital of other residential psychiatric medical facility * <input type="checkbox"/> Jail, prison, or juvenile detention facility* <input type="checkbox"/> Long-term care facility or nursing home*	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility* <input type="checkbox"/> Substance abuse treatment facility or detox center* <input type="checkbox"/> No, has not exited any of these facilities in the past two months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> 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)	<input type="checkbox"/> Foster care home or foster care group home* <input type="checkbox"/> Hospital of other residential psychiatric medical facility * <input type="checkbox"/> Jail, prison, or juvenile detention facility* <input type="checkbox"/> Long-term care facility or nursing home*	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility* <input type="checkbox"/> Substance abuse treatment facility or detox center* <input type="checkbox"/> No, has not exited any of these facilities in the past two months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
20b. Date left	____ / ____ / ____	

DPSS Crisis Housing Order Form

<input type="checkbox"/> TAY	<input type="checkbox"/> Disabled
------------------------------	-----------------------------------

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
22. Have you ever been told you have a learning disability or developmental disability?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
23. Do you have a chronic health condition? <i>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.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
24. Have you been diagnosed with AIDS or have you tested positive for HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
25. Do you feel you currently have a mental health disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
26. Do you <i>currently</i> have a drug or alcohol problem?	<input type="checkbox"/> No <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Both	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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. Responses without the two ** are not considered disabling conditions.

Client has a disabling condition	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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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?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to one year ago (excluding one year exactly) <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
---	---

27b. Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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27c. Are you experiencing homelessness because you are currently fleeing domestic violence, dating violence, sexual assault, or stalking? (ES, SH, TH Program also)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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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)	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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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?	<input type="checkbox"/> Agricultural work <input type="checkbox"/> Panhandling <input type="checkbox"/> Door-to-door sales <input type="checkbox"/> Restaurant/catering work <input type="checkbox"/> Household/childcare work <input type="checkbox"/> Illegal goods sales (drugs, guns, etc.)	<input type="checkbox"/> Sex work <input type="checkbox"/> Other <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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Tuberculosis – Emergency Shelters only, all fields required unless otherwise noted

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

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33. Have you been feeling much more tired than usual over the past month?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
34. Have you had fevers almost daily for more than one week?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> No*	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes**	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
If question #35 was answered as "No" (*), then the following question is required :		
35a. Are you.... (read options to the right)	<input type="checkbox"/> Looking for work	<input type="checkbox"/> Not looking for work
	<input type="checkbox"/> Unable to work	
If question #35 was answered as "Yes" (**), then the following question is required :		
35b. What type of employment do you have?	<input type="checkbox"/> Full-time	<input type="checkbox"/> Seasonal / sporadic
	<input type="checkbox"/> Part-time	(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?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
	<input type="checkbox"/> Yes**	<input type="checkbox"/> Client prefers not to answer	
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?			
<input type="checkbox"/> Earned Income (employment wages / cash)	\$	<input type="checkbox"/> Temporary Assistance for Needy Families (CalWorks)	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> General Assistance (GA) / General Relief (GR)	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> Retirement Income from Social Security	\$
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	\$	<input type="checkbox"/> Pension or retirement income from a former job	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$	<input type="checkbox"/> Child Support	\$
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$	<input type="checkbox"/> Alimony and other spousal support	\$
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/> Other Source (Specify: _____)	\$
<input type="checkbox"/> Worker's Compensation	\$		
Total Monthly Cash Income for Individual	\$		
36a. Cash Income Documentation Do you have documents that verify income?	<input type="checkbox"/> GR Form <input type="checkbox"/> Pay Stub <input type="checkbox"/> Utility Allowance <input type="checkbox"/> Child Support Forms <input type="checkbox"/> Social Security Forms <input type="checkbox"/> SSI Forms	<input type="checkbox"/> CalWORKs Form <input type="checkbox"/> Unemployment Insurance Forms <input type="checkbox"/> W-2 Forms <input type="checkbox"/> SSDI Form <input type="checkbox"/> Workmans Comp <input type="checkbox"/> Self Employment Docs	<input type="checkbox"/> Pension Letter/Stub <input type="checkbox"/> Unemployment Forms <input type="checkbox"/> Self Declaration <input type="checkbox"/> Employer Printout/Letter <input type="checkbox"/> VA Documentation <input type="checkbox"/> Other (Specify: _____)

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

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

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

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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		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Number of years in foster care:	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years		
Number of months in foster care:	<input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months	<input type="checkbox"/> 5 months <input type="checkbox"/> 6 months <input type="checkbox"/> 7 months <input type="checkbox"/> 8 months	<input type="checkbox"/> 9 months <input type="checkbox"/> 10 months <input type="checkbox"/> 11 months
Juvenile Justice System		<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Number of years in juvenile justice system:	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years		
Number of months in juvenile justice system:	<input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months	<input type="checkbox"/> 5 months <input type="checkbox"/> 6 months <input type="checkbox"/> 7 months <input type="checkbox"/> 8 months	<input type="checkbox"/> 9 months <input type="checkbox"/> 10 months <input type="checkbox"/> 11 months
Mandated stay in inpatient or outpatient mental health treatment facility		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Jail		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Prison		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Adult Probation		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Parole		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
If question #43 was answered as "Other" (**), then the following question is required :		
43a. Please describe:	_____	

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

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

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If the YHDP question above was answered as "Not currently enrolled" (*), then the following question is **required**:

YHDP: Most recent education status	<input type="checkbox"/> K12: Graduated from high school	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> K12: Obtained GED	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> K12: Dropped Out	<input type="checkbox"/> Data not collected
	<input type="checkbox"/> K12: Suspended	
	<input type="checkbox"/> K12: Expelled	
	<input type="checkbox"/> Higher education: Pursuing a credential but not currently attending	
	<input type="checkbox"/> Higher education: Dropped out	
	<input type="checkbox"/> Higher education: Obtained a credential/degree	

If the YHDP question above was answered as "Currently enrolled" (**), then the following question is **required**:

YHDP: Current educational status	<input type="checkbox"/> Pursuing a high school diploma or GED	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Pursuing Associate's Degree	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Pursuing Bachelor's Degree	<input type="checkbox"/> Data not collected
	<input type="checkbox"/> Pursuing Graduate Degree	
	<input type="checkbox"/> Pursuing other post-secondary credential	

SOAR Connection

75. Is the client connected with SOAR? (PATH, SSVF, or HoH/Adult aged 18 or older)	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> 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?	<input type="checkbox"/> Los Angeles County <input type="checkbox"/> Other county in Southern California (Kern, Imperial, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, or Ventura) <input type="checkbox"/> Other county in California <input type="checkbox"/> Out of state <input type="checkbox"/> Outside of the United States <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	

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

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

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Veteran Information (SSVF/VASH) – Head of Household only, all fields required unless otherwise noted

48. What is the AMI percentage for the Household's Income?

☐ 30% or less ☐ 31% to 50% ☐ 51% to 80% ☐ 81% or greater

49. VAMC Station Number

<input type="checkbox"/> (402) Togus, ME	<input type="checkbox"/> (544) Columbia, SC	<input type="checkbox"/> (612) N. California, CA	<input type="checkbox"/> (664) San Diego, CA
<input type="checkbox"/> (405) White River Junction, VT	<input type="checkbox"/> (546) Miami, FL	<input type="checkbox"/> (613) Martinsburg, WV	<input type="checkbox"/> (666) Sheridan, WY
<input type="checkbox"/> (436) Montana HCS	<input type="checkbox"/> (548) West Palm Beach, FL	<input type="checkbox"/> (614) Memphis, TN	<input type="checkbox"/> (667) Shreveport, LA
<input type="checkbox"/> (437) Fargo, ND	<input type="checkbox"/> (549) Dallas, TX	<input type="checkbox"/> (618) Minneapolis, MN	<input type="checkbox"/> (668) Spokane, WA
<input type="checkbox"/> (438) Sioux Falls, SD	<input type="checkbox"/> (550) Danville, IL	<input type="checkbox"/> (619) Central Alabama Veterans HCS, AL	<input type="checkbox"/> (671) San Antonio, TX
<input type="checkbox"/> (442) Cheyenne, WY	<input type="checkbox"/> (552) Dayton, OH	<input type="checkbox"/> (620) VA Hudson Vally HCS, NY	<input type="checkbox"/> (672) San Juan, PR
<input type="checkbox"/> (459) Honolulu, HI	<input type="checkbox"/> (553) Detroit, MI	<input type="checkbox"/> (621) Mountain Home, TNN	<input type="checkbox"/> (673) Tampa, FL
<input type="checkbox"/> (460) Wilmington, DE	<input type="checkbox"/> (554) Denver, CO	<input type="checkbox"/> (623) Muskogee, OK	<input type="checkbox"/> (674) Temple, TX
<input type="checkbox"/> (463) Anchorage, AK	<input type="checkbox"/> (556) Captain James A Lovell FHCC	<input type="checkbox"/> (626) Middle Tennessee HCS, TN	<input type="checkbox"/> (675) Orlando, FL
<input type="checkbox"/> (501) New Mexico HCS	<input type="checkbox"/> (557) Dublin, GA	<input type="checkbox"/> (629) New Orleans, LA	<input type="checkbox"/> (676) Tomah, WI
<input type="checkbox"/> (502) Alexandria, LA	<input type="checkbox"/> (558) Durham, NC	<input type="checkbox"/> (630) New York Harbor HCS, NY	<input type="checkbox"/> (678) Southern Arizona HCS
<input type="checkbox"/> (503) Altoona, PA	<input type="checkbox"/> (561) New Jersey HCS, NJ	<input type="checkbox"/> (631) VA Central Western Massachusetts HCS	<input type="checkbox"/> (679) Tuscaloosa, AL
<input type="checkbox"/> (504) Amarillo, TX	<input type="checkbox"/> (562) Erie, PA	<input type="checkbox"/> (632) Northport, NY	<input type="checkbox"/> (687) Walla Walla, Wa
<input type="checkbox"/> (506) Ann Arbor, MI	<input type="checkbox"/> (564) Fayetteville, AR	<input type="checkbox"/> (635) Oklahoma City, OK	<input type="checkbox"/> (688) Washington, DC
<input type="checkbox"/> (508) Atlanta, GA	<input type="checkbox"/> (565) Fayetteville, NC	<input type="checkbox"/> (636) Nebraska-W Iowa, NE	<input type="checkbox"/> (689) VA Conneticut HCS, CT
<input type="checkbox"/> (509) Augusta, GA	<input type="checkbox"/> (568) Black Hills HCS, SD	<input type="checkbox"/> (637) Asheville, NC	<input type="checkbox"/> (691) Greater Los Angeles HCS
<input type="checkbox"/> (512) Baltimore HCS, MD	<input type="checkbox"/> (570) Fresno, CA	<input type="checkbox"/> (640) Palo Alto, CA	<input type="checkbox"/> (692) White City, OR
<input type="checkbox"/> (515) Battle Creek, MI	<input type="checkbox"/> (573) Gainesville, FL	<input type="checkbox"/> (642) Philadelphia, PA	<input type="checkbox"/> (693) Wilkes-Barre, PA
<input type="checkbox"/> (516) Bay Pines, FL	<input type="checkbox"/> (575) Grand Junction, CO	<input type="checkbox"/> (644) Phoenix, AZ	<input type="checkbox"/> (695) Milwaukee, WI
<input type="checkbox"/> (517) Beckley, WV	<input type="checkbox"/> (578) Hines, IL	<input type="checkbox"/> (646) Pittsburgh, PA	<input type="checkbox"/> (740) VA Texas Vally Coastal Bend HCS
<input type="checkbox"/> (518) Bedford, MA	<input type="checkbox"/> (580) Houston, TX	<input type="checkbox"/> (648) Portland, OR	<input type="checkbox"/> (756) El Paso, TX
<input type="checkbox"/> (519) Big Spring, TX	<input type="checkbox"/> (581) Huntington, WV	<input type="checkbox"/> (649) Northern Arizona HCS	<input type="checkbox"/> (757) Columbus, OH
<input type="checkbox"/> (520) Gulf Coast HCS, MS	<input type="checkbox"/> (583) Indianapolis, IN	<input type="checkbox"/> (650) Providence, RI	<input type="checkbox"/> (459GE) Guam
<input type="checkbox"/> (521) Birmingham, AL	<input type="checkbox"/> (585) Iron Mountain, MI	<input type="checkbox"/> (652) Richmond, VA	<input type="checkbox"/> (528A5) Canadaiagua, NY
<input type="checkbox"/> (523) VA Boston HCS, MA	<input type="checkbox"/> (586) Jackson, MS	<input type="checkbox"/> (653) Roseburgg, OR	<input type="checkbox"/> (528A6) Bath, NY
<input type="checkbox"/> (526) Bronx, NY	<input type="checkbox"/> (589) Kansas City, MO	<input type="checkbox"/> (654) Reno, NV	<input type="checkbox"/> (528A7) Syracuse, NY
<input type="checkbox"/> (528) Western New York, NY	<input type="checkbox"/> (590) Hampton, VA	<input type="checkbox"/> (655) Saginaw, MI	<input type="checkbox"/> (528A8) Albany, NY
<input type="checkbox"/> (529) Butler, PA	<input type="checkbox"/> (593) Las Vegas, NV	<input type="checkbox"/> (656) St. Cloud, MN	<input type="checkbox"/> (589A4) Comlumbia, MO
<input type="checkbox"/> (531) Boise, ID	<input type="checkbox"/> (596) Lexington, KY	<input type="checkbox"/> (657) St. Louis, MO	<input type="checkbox"/> (589A5) Kansas City, MO
<input type="checkbox"/> (534) Charleston, SC	<input type="checkbox"/> (598) Little Rock, AR	<input type="checkbox"/> (658) Salem, VA	<input type="checkbox"/> (589A6) Eastern KS HCS, KS
<input type="checkbox"/> (537) Jesse Brown VAMC (Chicago), IL	<input type="checkbox"/> (600) Long Beach, CA	<input type="checkbox"/> (659) Salisbury, NC	<input type="checkbox"/> (589A7) Wichita, KS
<input type="checkbox"/> (538) Chillicothe, OH	<input type="checkbox"/> (603) Louisville, KY	<input type="checkbox"/> (660) Salt Lake City, UT	<input type="checkbox"/> (636A6) Central Iowa, IA
<input type="checkbox"/> (539) Cincinnati, OH	<input type="checkbox"/> (605) Loma Linda, CA	<input type="checkbox"/> (662) San Francisco, CA	<input type="checkbox"/> (636A8) Iowa City, IA
<input type="checkbox"/> (540) Clarksburg, WV	<input type="checkbox"/> (607) Madison, WA	<input type="checkbox"/> (663) VA Puget Sound, Wa	<input type="checkbox"/> (657A4) Poplar Bluff, MO
<input type="checkbox"/> (541) Cleveland, OH	<input type="checkbox"/> (608) Manchester, NH		<input type="checkbox"/> (657A5) Marion, IL
<input type="checkbox"/> (542) Coatesville, PA	<input type="checkbox"/> (610) Northern Indiana HCS, IN		

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SSVF HP Targeting Criteria – SSVF Homelessness Prevention projects only, required for Head of Household

Is Homelessness Prevention targeting screeners required?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
Current housing loss expected within:	
<input type="checkbox"/> 0-6 days	<input type="checkbox"/> 14-21 days
<input type="checkbox"/> 7-13 days	<input type="checkbox"/> More than 21 days (0 points)
Current household income?	
<input type="checkbox"/> \$0 (i.e., not employed, not receiving cash benefits, no other current income)	
<input type="checkbox"/> 1-14% of Area Median Income (AMI) for household size	
<input type="checkbox"/> 15-30% of AMI for household size	
<input type="checkbox"/> More than 30% of AMI for household size	
Past experience of homelessness (street/shelter/transitional housing) (any adult)	
<input type="checkbox"/> Most recent episode occurred within the last year	<input type="checkbox"/> Most recent episode occurred more than one year ago
<input type="checkbox"/> None	
Head of Household is not a current leaseholder/renter of unit?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
Head of Household has never been a leaseholder/renter of unit?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit	
<input type="checkbox"/> No (0 points)	<input type="checkbox"/> Yes
Rental Evictions within the past 7 years?	
<input type="checkbox"/> No prior rental evictions	<input type="checkbox"/> prior rental evictions
<input type="checkbox"/> 2 or more prior rental evictions	
Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property	
<input type="checkbox"/> No (0 points)	<input type="checkbox"/> Yes
Incarcerated as adult (adults in household)	
<input type="checkbox"/> Not incarcerated	<input type="checkbox"/> Incarcerated once
<input type="checkbox"/> Incarcerated two or more times	
Discharged from jail or prison within last six months after incarceration of 90 days or more (adults)?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
Registered sex offender (all household members)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing	
<input type="checkbox"/> No (0 points)	<input type="checkbox"/> Yes
Currently pregnant? (any household member)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
Single parent/guardian household with minor child(ren)?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

Household includes one or more young children (age six or under) or a child who requires significant care?	
<input type="checkbox"/> No <input type="checkbox"/> Youngest child is under 1 year old	
<input type="checkbox"/> Youngest child is 1 to 6 years old and/or one or more children (any age) require significant care.	
Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
Household includes one or more members of an overrepresented population in the homelessness system when compared to the general population	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
HP applicant total points	Grantee targeting threshold score

RHY – All RHY projects only EXCEPT for Street Outreach, all fields required unless otherwise noted

76. Referral Source	<input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual <input type="checkbox"/> Outreach Project* <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Residential Project <input type="checkbox"/> Hotline <input type="checkbox"/> Child Welfare/CPS <input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Law Enforcement/Police <input type="checkbox"/> Mental Hospital <input type="checkbox"/> School <input type="checkbox"/> Other Organization <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
If question #76 was answered as "Outreach Project" (*), then the following question is required :		
76a. Number of times approached by outreach prior to entering the project _____		
77. Which of these critical issues affects one of your family members? (Choose all that apply)	<input type="checkbox"/> Unemployment <input type="checkbox"/> Alcohol or Substance Use Disorder <input type="checkbox"/> Mental Health Disorder <input type="checkbox"/> Insufficient Income to Support Youth <input type="checkbox"/> Physical Disability <input type="checkbox"/> Incarcerated Parent of Youth	

RHY BCP – RHY Basic Center Projects only, all fields required unless otherwise noted

78. Has the youth's BCP status been determined?	<input type="checkbox"/> No <input type="checkbox"/> Yes** 78a. Date of Determination: _____ / _____ / _____
If question #78 was answered as "Yes" (**), then the following question is required :	
78b. Is the youth eligible for RHY services?	<input type="checkbox"/> No* <input type="checkbox"/> Yes**
If question #78b was answered as "No" (*), then the following question is required :	
78c. Reason why services are not funded by BCP grant	<input type="checkbox"/> Out of age range <input type="checkbox"/> Ward of the state – immediate reunification <input type="checkbox"/> Ward of the criminal justice system – immediate reunification <input type="checkbox"/> Other
If question #78b was answered as "Yes" (**), then the following question is required :	
78d. Is the youth a runaway?	<input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Yes <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

HOPWA – Medical Assistance; required if answered “yes” to #24

85. Receiving AIDS Drug Assistance Program (ADAP)?	<input type="checkbox"/> No* <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
If question #85 was answered as “No” (*), then the following question is required :		
85a. Reason	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
86. Receiving Ryan White-funded Medical or Dental Assistance?	<input type="checkbox"/> No* <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
If question #86 was answered as “No” (*), then the following question is required :		
85a. Reason	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

HOPWA – T-cell (CD4) and Viral load; required if answered “yes” to #24

87. T-cell (CD4) count available?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
If question #86 was answered as “Yes” (**), then the following question is required :		
87a. T-cell count		
87b. How was the data obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report	<input type="checkbox"/> Other
88. Viral load available?	<input type="checkbox"/> Not available <input type="checkbox"/> Available** <input type="checkbox"/> Undetectable**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
If question #87 was answered as “Available” or “Undetectable” (**), then the following question is required :		
88a. Viral load		
88b. How was the data obtained?	<input type="checkbox"/> Not available <input type="checkbox"/> Available** <input type="checkbox"/> Undetectable**	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Has the participant been prescribed anti-retroviral drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

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