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 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.

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.

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 :(_____) _____
<div align="center">(If different from applicant)</div>

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: _____ _____
<div align="center">Signature   Date</div>

Case Manager: _____ _____
<div align="center">Signature   Date</div>

Program Manager _____ _____
<div align="center">Print Name   Date</div>

Program Manager: _____ _____
<div align="center">Signature   Date</div>

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

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

INCOME STATUS

What is the applicant's total monthly income? $ _____ **Total monthly expenses?** $ _____

Indicate the source(s) of income on the HMIS Intake and Enrollment Form, page 2.

FAMILY COMPOSITION

Family Type: **Number of Children**
❑ Single Adult   ❑ 1
❑ Adult w / child   ❑ 2
❑ Adult w / children   ❑ 3
❑ Two Adults   ❑ 4
❑ Two Adults w / child   ❑ 5 or more
❑ Two Adults w / children

Give a brief description of why the applicant needs housing assistance:

Location of the applicant's most recent episode of homelessness:

❑ SA 1 Antelope Valley   ❑ SA 5 West LA
❑ SA 2 San Fernando Valley   ❑ SA 6 South LA
❑ SA 3 San Gabriel Valley   ❑ SA 7 South East
❑ SA 4 Metro LA   ❑ SA 8 Harbor

EVICTION PREVENTION REQUEST **(Only complete if applying for eviction prevention funding)**

Monthly rent $_____

How many months has the applicant lived at the present address?   _____ Months

Amount behind in rent:
$ _____
Note: The payment of rent in arrears cannot exceed one month's rent plus a reasonable documented late charge.
Is the client in imminent risk of losing his/her housing within the next 14 days? YES___ NO___

Has the applicant received one of the following? (*Please state date notice was received*)

❑ 3 Day Notice to Pay or Quit   (Date: _____)

❑ 5 day Marshall Notice to Vacate   (Date: _____)

❑ 30 day Notice   (Date: _____)

❑ Unfavorable Court Judgment   (Date: _____)

ONLY COMPLETE IF APPLYING FOR HOUSEHOLD GOODS AND/OR UTILITY DEPOSIT

Applicant's Name: _____

Agency Name: _____

UTILITY REQUEST: ☐ **Electricity**   ☐ **Water**   ☐ **Gas**

FURNITURE AND/OR UTILITY VENDOR INFORMATION:

Vendor _____Amount requesting: $_____

Contact: _____ Phone: (____) _____

Vendor: _____ Amount requesting: $_____

Contact: _____ Phone: (____) _____

Please list Household Goods items that are being purchase (attach additional sheet if necessary)

VENDOR NAME	DESCRIPTION OF ITEMS	COST		
		UNIT COST	QUANTITY	TOTAL COST
		TOTAL AMOUNT OF REQUEST:		

CERTIFICATION
The agency declares and certifies each of the following statements to be true and correct:
♦   The agency has verified that the applicant is in need of the requested items and that the requested expenditures are consistent with program guidelines.

♦   The agency has verified and explained to applicant that the request is not to exceed the limited allocation of $2,000 for household goods unless the applicant is in a Directly-Operated FSP program in which case the limit is not to exceed $2,500).

Case Manager: _____ _____
Signature   Date
Program Manager _____ _____
Print Name   Date
Program Manager: _____ _____
Signature   Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

TEMPORARY RENTAL ASSISTANCE REQUEST FORM
(DMH Directly-Operated FSP <u>ONLY</u>)

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:

❑ Sober Living Home   ❑ Transitional Housing
❑ Shared/Collaborative Housing   ❑ Apartment
❑ Residential Treatment Program   ❑ 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**

Complete if applying for Security Deposit and/or Temporary Rental Assistance.	Complete if applying for Eviction Prevention.
Security deposit amount: $_____	Rent: $_____
Regular month's rent: $_____	Late charges (as stated in lease): $_____
Tenant's rent portion: $_____	Tenant's rent portion: $_____

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)
Amount Approved for payment: $_____**Initialed By:**_____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HOUSING DIVISION

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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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	Types of Housing: ☐ Project Based Housing with subsidy ☐ Continuum of Care Certificate ☐ Section 8 Voucher ☐ Adult Residential Facility ☐ Non-subsidized Apartment/Room/House Other_____	Case Manager and Client		
Goal #2 To access financial resources for housing	Apply for PATH funds: ☐ Move-In Assistance ☐ Eviction Prevention ☐ Household Goods Assistance ☐ 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: ☐ Psychiatric Services ☐ Medication Support ☐ Case Management ☐ Individual and Group Therapy ☐ Employment/Educ./Voc. Services ☐ 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 (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name

Last Name

Street Address

City, State, Zip

IS Number

Birth Date

(   )
Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

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

REDISCLOSURE NOTICE:

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

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:
The following information will be disclosed in accordance with Projects for Assistance in Transition from Homelessness (PATH) grant reporting requirements such as: demographics, veteran status, living situation, co-occurring disorders, barriers, homeless history, employment, income, benefits, insurance, health, services, referrals, outcomes (whether client was assisted with household goods, security deposits, maintenance, rehabilitation/repairs, eviction prevention and utility deposits).

Purpose of Disclosure:
My PHI will be used to coordinate services and comply with PATH grant reporting and outcome data requirements.

Neither LACDMH 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 (LACDMH)

N O T I C E
COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.   *LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.*

EXPIRATION DATE
Expiration Date: Date may not exceed five (5) years from the date signed. If no expiration date is indicated, expiration date will expire five (5) years from the date signed. This authorization is valid until: _____

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 Division, 510 S. Vermont Avenue, Los Angeles, CA 90020**. I also understand that a revocation will be effective upon receipt but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION
_____   _____   **Signature of Client/Individual/Personal Representative**   **Date**   If signed by other than client, state relationship and authority to do so:

AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION
HOUSING ASSISTANCE PROGRAM
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: Los Angeles County Department of Mental Health (LACDMH) and/or Brilliant Corners to use, receive, share and/or disclose my PHI, as described below, to property owners; property management companies; and/or vendors of appliances, furniture, and/or other household goods in order to assist homeless individuals with move-in assistance such as security deposits, household goods, eviction prevention, ongoing rental assistance, utility assistance and minor rehabilitative repairs funded by LACDMH.

REDISCLOSURE 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:

Information contained in the Housing Assistance Program – Universal Application such as acknowledgment of currently receiving mental health services, verification of other medical conditions or co-occurring disorders, demographics, income, current address, social security number, employment information, the length of homelessness, and any additional information that would assist an individual/family applying for move in assistance funds under the Housing Assistance Program. In addition, any information required for data collection, program evaluation and/or monitoring such as program affiliation, homeless verification, demographics, use of funds, duration of housing stay, income, and frequency, type and financial value of mental health services.

Purpose of Disclosure:

My PHI may be used to determine eligibility and implementation of the LACDMH funded Housing Assistance Program administered by Brilliant Corners for security deposits, assistance with locating and/or maintaining permanent housing, advocacy and/or program implementation with property owners or property management companies and compliance with data collection and monitoring/evaluation requirements of the program.

AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION
HOUSING ASSISTANCE PROGRAM
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

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

N O T I C E

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

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

EXPIRATION DATE

Expiration Date: This authorization remains valid until the individual or family has vacated the unit that a security deposit or ongoing rental assistance was paid on their behalf, and/or indicated complete satisfaction with any household goods or other services 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 Division, 510 S. Vermont Avenue, Los Angeles, CA 90020**. I also understand that a revocation will be effective upon receipt but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative   **Date**

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

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HOUSING DIVISION

AGENCY VERIFICATION OF HOMELESSNESS

CHECK THE APPROPRIATE BOXES UNDER HOMELESS <u>OR</u> CHRONICALLY HOMELESS

I certify that _____ is
<div align="center">(Name of Applicant)</div>

❑ **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).

    <u>OR</u>

❑ **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 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_____

Form **W-9**

(Rev. March 2024)

Department of the Treasury
Internal Revenue Service

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.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . _____

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) _____

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____

(Applies to accounts maintained outside the United States.)

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. See also *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:

1. 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

2. 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

3. I am a U.S. citizen or other U.S. person (defined below); and

4. 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

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*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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-NEC (nonemployee compensation).

• 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), and 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.

Caution: If you don't 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; and

4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and

5. 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).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

• In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded 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 grantor trust.

• In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

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 (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

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 their 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 their 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, but are not limited to, 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, as described in item 4 under "*By signing the filled-out form*" 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.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. 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 are no longer 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.

• **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 for 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 you filed with your application.

• **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

• **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** 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.

• **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. Enter any business, trade, or DBA name on line 2.

• **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner 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. 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, enter it on line 2.

Line 3a

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

IF the entity/individual on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation.
• Individual or • Sole proprietorship	Individual/sole proprietor.
• LLC classified as a partnership for U.S. federal tax purposes or • LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	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 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

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 on 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 territory, 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 territory.

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 as defined under section 581.

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 Information, 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) entered 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 territory, 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, enter "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 ITIN. Enter it in the entry space for the Social security number. 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). 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 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/EIN*. 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 Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "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, you will generally 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. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

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 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor*

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
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 Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (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 on line 1, and enter your business or DBA name, if any, on line 2. 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.)

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

** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

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 return 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 a questionable credit report, contact the IRS Identity Theft Hotline at 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 877-777-4778 or TTY/TDD 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 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.

Go to *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 territories for use in administering their laws. The information may also 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, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.

Los Angeles Collaborative

HMIS Intake and Enrollment

Form

2026

Updated 10/1/2025

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 records 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/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 Organizations has signed an agreement to maintain the security and confidentiality of the information. In some instances, when the Participating Organizations 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), shared with other Participating Organizations as described in this consent form.

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

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

Signature _____Date _____

☐ **Head of Household (Check here)**

Minor Children (if any):

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

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

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

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

_____   _____
Signature of Organization Staff   **Date**

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

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

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

HMIS Intake and Enrollment Form

Primary Language	☐ English ☐ Spanish ☐ French ☐ Italian ☐ German ☐ Greek ☐ Polish	☐ Portugese ☐ Russian ☐ Swedish ☐ American Sign Language ☐ Other (specify:_____) ☐ Client doesn't know ☐ Client prefers not to answer
TB Clearance Date	_____/_____/_____	Clinic:
DPSS ID	_____	
ILP eligibility confirmed? (*to be completed by SPA matcher.***)**	☐ No ☐ Yes	☐ Undetermined
DMH eligibility confirmed?	☐ No ☐ Yes	☐ Undetermined
Reviewed for COVID-19 vulnerability and Project Room Key?	☐ No ☐ Yes ☐ Potentially eligible	☐ N/A (housed) ☐ Missing key data/client follow up necessary
ADA Information Does the participant or anyone in this household have a disability?		☐ Yes ☐ No
ADA Information Does the particpant or anyone in this household have a disability and need or could benefit from mobility features to accomodate access for a wheelchair, walker, cane, or assitive device?		☐ Yes ☐ No

If the client identifes as "Yes"(**) to either ADA Information, then the following questions are required:		
	Please select any of the assistance devises that are used:	☐ Elevator (no stairs), 1st Floor or Bottom Bunk ☐ Wheelchair accessible ☐ Other
	If Other: Please provide other assistive devices needed	
	For Case Manager/Staff: Based on your observation, is the disability apparent?	☐ Yes ☐ No
	If No: For Case Manager/Staff: Please provide a statement that verifies the Participant's disability and/or need for an accessible unit	
	Does the participant or anyone in this household have a disability and need or could benefit from other mobility features?	☐ Yes ☐ No
	If Yes: Select what feature would be helpful:	☐ Accessible Tub or Shower ☐ Oxygen Tank ☐ Service Animal/Emotional Support Animal ☐ Other
	If Other: Please provide other features that would be helpful	

If Yes: For Case Manager/Staff: Based on your observation, is the disability apparent?	☐ Yes ☐ No	
If No: For Case Manager/Staff: Please provide a statement that verifies the Participant's disability and/or need for an accessible unit		
Does the participant or anyone in this household have a disability and need or could benefit from sensory (hearing and/or visual) features?	☐ Yes ☐ No	
If Yes: Select which accommodations are needed:	☐ Visually Impaired ADA Accommodations ☐ Hearing Impaired ADA Accommodations	
If Yes: For Case Manager/Staff: Based on your observation, is the disability apparent?	☐ Yes ☐ No	
If No: For Case Manager/Staff: Please provide a statement that verifies the Participant's disability and/or need for an accessible unit		

Veteran Status	☐ No ☐ Yes	☐ Don't know ☐ Client prefers not to answer ☐ Data not collected
If the client identifies as "Yes" (**) to veteran status, then the following questions (**except VHA Eligible and VASH Status**) are **required**:	If the client identifies as "Yes" (**) to veteran status, then the following questions (except VHA Eligible and VASH Status) are required:	If the client identifies as "Yes" (**) to veteran status, then the following questions (except VHA Eligible and VASH Status) are required:

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

Dates of military service (Year Only)	_____ to _____
Veteran Health Administration (VHA) Eligible	☐ No ☐ Yes

VASH Status	☐ Admitted ☐ Ineligible background (not eligible because of criminal background) ☐ Ineligible case management (ineligible because they currently do not need that level of case management)	☐ Ineligible Veteran Health Administration (VHA) (ineligible because they are not VA healthcare eligible) ☐ Interested list ☐ Needs screening	☐ Vouchered ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

HMIS Intake and Enrollment Form

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

HMIS Intake and Enrollment Form

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

First Point of Contact	
Point of Contact Date	_____/_____/_____
Point of Contact Name	
Point of Contact Phone	Extension:
Point of Contact Email	
Point of Contact Supervisor or Manager Name	
Point of Contact Supervisor or Manager Phone Number	Extension:
Point of Contact Supervisor or Manager Email	
Point of Contact Category	☐ LAHSA Funded Access Center ☐ LAHSA Funded Housing Navigation Program ☐ LAHSA Funded Interim Housing (Bridge) ☐ LAHSA Funded Interim Housing (Crisis) ☐ LAHSA Funded Interim Housing (Host Home) ☐ LAHSA Funded Street Outreach Program ☐ DHS Funded Countywide Benefits Entitlement Services Team (CBEST) ☐ DHS Funded E6 Multi-Disciplinary Outreach Team ☐ DHS Funded Interim Housing ⟨col2⟩ ☐ DHS Funded Interim Housing Intensive Case Management (ICMS) Program ☐ DMH Funded Full Service Partnership Program ☐ DMH Funded Housing Specialist and Housing Liaisons ☐ DMH Funded Interim Housing ☐ DMH Funded Recovery Resilience and Reintegration Services ☐ DPH Funded Substance Use Disorder Case Manager ☐ Other (specify:_____)

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

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

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

HMIS Intake and Enrollment Form

Client Contact Information *(Location)*

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

Current Living Situation *(Location)*

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

HMIS Intake and Enrollment Form

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

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

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

Home Safe Referral ID: _____

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

CES Placement *– Permanent Housing and Transitional Housing only*

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

Housing Move-In *– Rapid Re-housing, Permanent Housing, Street Outreach, and GPD Case Management / Housing Retention projects only, only required for Head of Household*

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

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

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

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

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

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

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

HMIS Intake and Enrollment Form

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

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

HMIS Intake and Enrollment Form

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

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

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

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

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

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

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

Client Name / HMIS ID: _____

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

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

☐ TAY   ☐ Disabled

HMIS Intake and Enrollment Form

___Disabling Conditions and Barriers___ *– For adults 18 and older and/or Head of Household, all fields required except for VA and VASH Funded Programs*

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

HMIS Intake and Enrollment Form

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

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

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

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

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

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

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

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

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

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

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

36. Do you receive any cash income?	☐ No ☐ Client doesn't know ☐ Data not collected ☐ Yes** ☐ 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?*			
☐ Earned Income (employment wages / cash)	$	☐ Temporary Assistance for Needy Families (CalWorks)	$
☐ Unemployment Insurance	$	☐ General Assistance (GA) / General Relief (GR)	$
☐ Supplemental Security Income (SSI)	$	☐ Retirement Income from Social Security	$
☐ Social Security Disability Insurance (SSDI)	$	☐ Pension or retirement income from a former job	$
☐ VA Service-Connected Disability Compensation	$	☐ Child Support	$
☐ VA Non-Service-Connected Disability Pension	$	☐ Alimony and other spousal support	$
☐ Private Disability Insurance	$	☐ Other Source (Specify:_____)	$
☐ Worker's Compensation	$		
Total Monthly Cash Income for Individual	$		

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

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

37. Do you receive any non-cash benefits?	☐ No ☐ Client doesn't know ☐ Data not collected ☐ Yes** ☐ Client prefers not to answer

If question #37 was answered as "Yes" (**), then the following question is **required**:	
Non-Cash Benefits *What non-cash benefits do you receive? (Check all that apply)*	☐ Food Stamps/CalFresh (Supplemental Nutrition Assistance Program, SNAP) ☐ WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) ☐ CalWorks child care services ☐ CalWorks transportation services ☐ Other CalWorks-funded services ☐ Other source (Specify): _____

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

38. Are you covered by any type of health insurance?	☐ No* ☐ Client doesn't know ☐ Data not collected ☐ Yes** ☐ Client prefers not to answer

If question #38 was answered as "No" (*), then the following questions are **required**:	
Reason	☐ Applied; decision pending ☐ Client doesn't know ☐ Applied; client not eligible ☐ Client prefers not to answer ☐ Client did not apply ☐ Data not collected ☐ Insurance type N/A for this client

If question #38 was answered as "Yes" (**), then the following questions are **required**:		
38a. Health Insurance *(Check all that apply):*	☐ Medi-Cal (MEDICAID) ☐ MEDICARE ☐ State Children's Health Insurance Program (SCHIP) ☐ VA medical services ☐ Employer-provided health insurance ☐ COBRA	☐ Private pay health insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other health insurance (Specify:_____)
38b. Health Insurance Provider	☐ Health Net ☐ Molina ☐ My Health LA (DHS) ☐ Anthem Blue Cross ☐ Kaiser Permanente ☐ VA	☐ L.A. Care ☐ Care 1st Health Plan ☐ SCAN Health Plan ☐ Other ☐ Unknown

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

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

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

	Number of years in foster care:	☐ Less than one year	☐ 1 to 2 years	☐ 3 to 5 or more years
	Number of months in foster care:	☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months	☐ 5 months ☐ 6 months ☐ 7 months ☐ 8 months	☐ 9 months ☐ 10 months ☐ 11 months

Juvenile Justice System	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

	Number of years in juvenile justice system:	☐ Less than one year	☐ 1 to 2 years	☐ 3 to 5 or more years
	Number of months in juvenile justice system:	☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months	☐ 5 months ☐ 6 months ☐ 7 months ☐ 8 months	☐ 9 months ☐ 10 months ☐ 11 months

Mandated stay in inpatient or outpatient mental health treatment facility	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Jail	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Prison	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Adult Probation	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Parole	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

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

43. Which of the following best represents how you think about yourself?	☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Questioning/Unsure ☐ Other**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
If question #43 was answered as "Other" (**), then the following question is **required**:		
43a. Please describe:	_____	

HMIS Intake and Enrollment Form

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

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

HMIS Intake and Enrollment Form

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

SOAR Connection

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

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

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

HMIS Intake and Enrollment Form

Translation Assistance Needed – *Head of Household only, all fields Not required unless otherwise noted*

Is translation assistance needed?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

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

Preferred Language	☐ English
	☐ Spanish
	☐ Russian
	☐ French
	☐ Armenian
	☐ American Sign
	   Language
		☐ Portugese
		☐ Chinese
		☐ Albanian
		☐ Korean
		☐ Farsi
		☐ Italian
		☐ Arabic
			☐ German
			☐ Vietnamese
			☐ Ukrainian
			☐ Greek
			☐ Polish
			☐ Swedish
			☐ Japanese
				☐ Different Preferred
				   Language**
				☐ Client doesn't know
				☐ Client prefers not to answer
				☐ Data not collected

If the question above was answered as "Different Preferred Language" (**), then the following question is **required**:

Specify different preferred language:	

Only required for CoC/HHS/VA funding – *Head of Household only, all fields required unless otherwise noted*

Sex	☐ Female ☐ Male ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

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

HMIS Intake and Enrollment Form

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

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

HMIS Intake and Enrollment Form

Client Name / HMIS ID: _____

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

Is Homelessness Prevention targeting screeners required?	
☐ No	☐ Yes

Current housing loss expected within:	
☐ 0-6 days	☐ 14-21 days
☐ 7-13 days	☐ More than 21 days (0 points)

Current household income?
☐ $0 (i.e., not employed, not receiving cash benefits, no other current income)
☐ 1-14% of Area Median Income (AMI) for household size
☐ 15-30% of AMI for household size
☐ More than 30% of AMI for household size

Past experience of homelessness (street/shelter/transitional housing) (any adult)	
☐ Most recent episode occurred within the last year	☐ Most recent episode occurred more than one year ago ☐ None

Head of Household is not a current leaseholder/renter of unit?	
☐ No	☐ Yes

Head of Household has never been a leaseholder/renter of unit?	
☐ No	☐ Yes

Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit	
☐ No (0 points)	☐ Yes

Rental Evictions within the past 7 years?		
☐ No prior rental evictions	☐ prior rental evictions	☐ 2 or more prior rental evictions

Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property	
☐ No (0 points)	☐ Yes

Incarcerated as adult (adults in household)		
☐ Not incarcerated	☐ Incarcerated once	☐ Incarcerated two or more times

Discharged from jail or prison within last six months after incarceration of 90 days or more (adults)?	
☐ No	☐ Yes

Registered sex offender (all household members)	
☐ No	☐ Yes

Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing	
☐ No (0 points)	☐ Yes

Currently pregnant? (any household member)	
☐ No	☐ Yes

Single parent/guardian household with minor child(ren)?	
☐ No	☐ 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?
☐ No   ☐ Youngest child is under 1 year old
☐ 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 household composition).
☐ No   ☐ Yes

Households which may include one or more members meeting other criteria for targeting prevention determined by the CoC.
☐ No   ☐ 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	☐ Self-Referral ☐ Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual ☐ Outreach Project* ☐ Temporary Shelter ☐ Residential Project ☐ Hotline ☐ Child Welfare/CPS ☐ Juvenile Justice	☐ Law Enforcement/Police ☐ Mental Hospital ☐ School ☐ Other Organization ☐ Client doesn't know ☐ Client prefers not to answer ☐ 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)	☐ Unemployment ☐ Alcohol or Substance Use Disorder ☐ Mental Health Disorder ☐ Insufficient Income to Support Youth ☐ Physical Disability ☐ 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?	☐ No ☐ 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?	☐ No* ☐ Yes**	
If question #78b was answered as "No" (*), then the following question is **required**:		
78c. Reason why services are not funded by BCP grant	☐ Out of age range ☐ Ward of the state – immediate reunification ☐ Ward of the criminal justice system – immediate reunification ☐ Other	
If question #78b was answered as "Yes" (**), then the following question is **required**:		
78d. Is the youth a runaway?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

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HMIS Intake and Enrollment Form

HOPWA – *Medical Assistance; required if answered "yes" to #24*

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

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

87. T-cell (CD4) count available?	☐ No ☐ Yes**	☐ Client doesn't know ☐ Client prefers not to answer ☐ 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?	☐ Medical report ☐ Client report	☐ Other
88. Viral load available?	☐ Not available ☐ Available** ☐ Undetectable**	☐ Client doesn't know ☐ Client prefers not to answer ☐ 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?	☐ Not available ☐ Available** ☐ Undetectable**	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Has the participant been prescribed anti-retroviral drugs?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected