

MHSA Housing Certification Application

Section 1. Referral Source		FOR OFFICE USE ONLY			
<input type="checkbox"/> MHSA Housing Program <input type="checkbox"/> MHSA Housing Trust Fund <input type="checkbox"/> Both		Date Received ____/____/____ <input type="checkbox"/> Approved <input type="checkbox"/> Denied Date ____/____/____ Initials _____			
Referring Agency _____ / _____ / _____					
Address _____		City _____	Zip Code _____		
Contact Name _____			Phone _____		
Email _____					
Section 2. Applicant Information					
Name _____		Phone Number/Message Number _____	Date _____		
Social Security Number _____		Date of Birth _____	Gender _____		
Mailing Address (Address Where Mail Can Be Received) _____		City _____	Zip Code _____		
			IS Number _____		
Section 3. MHSA Eligibility Criteria (check all that apply)					
<input type="checkbox"/> Adult or older adult with a severe and persistent mental illness (as defined in Welfare and Institutions Code 5600.3) <input type="checkbox"/> Child/adolescent with severe emotional disturbance (as defined in Welfare and Institutions Code 5600.3) <input type="checkbox"/> Individual has a co-occurring mental health and substance abuse disorder <input type="checkbox"/> Current mental health service provider: _____ <input type="checkbox"/> Tenant has declined mental health services					
Section 4. Homeless or At Risk of Homelessness Status (check all that apply)					
Length of most recent episode of homelessness: _____ <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Living on the streets <input type="checkbox"/> Living in an emergency shelter or in transitional housing <input type="checkbox"/> Living in an institutional setting (e.g. jail, juvenile hall/camp, psychiatric hospital or IMD) and will be homeless upon release <input type="checkbox"/> Lacking a fixed, regular and adequate nighttime residence <input type="checkbox"/> Temporarily living in a residential care facility <input type="checkbox"/> Facing eviction & unable to identify a new residence </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Living in an overcrowded setting in which they do not hold a lease <input type="checkbox"/> Living in substandard housing subject to an official notice to vacate <input type="checkbox"/> Paying more than 50% of income in housing costs <input type="checkbox"/> "Doubling up" or "couch surfing" due to economic hardship <input type="checkbox"/> Living in motels, hotels, trailer parks or camp grounds <input type="checkbox"/> Victim of domestic violence who is unable to obtain housing <input type="checkbox"/> Other (please explain): _____ </td> </tr> </table>				<input type="checkbox"/> Living on the streets <input type="checkbox"/> Living in an emergency shelter or in transitional housing <input type="checkbox"/> Living in an institutional setting (e.g. jail, juvenile hall/camp, psychiatric hospital or IMD) and will be homeless upon release <input type="checkbox"/> Lacking a fixed, regular and adequate nighttime residence <input type="checkbox"/> Temporarily living in a residential care facility <input type="checkbox"/> Facing eviction & unable to identify a new residence	<input type="checkbox"/> Living in an overcrowded setting in which they do not hold a lease <input type="checkbox"/> Living in substandard housing subject to an official notice to vacate <input type="checkbox"/> Paying more than 50% of income in housing costs <input type="checkbox"/> "Doubling up" or "couch surfing" due to economic hardship <input type="checkbox"/> Living in motels, hotels, trailer parks or camp grounds <input type="checkbox"/> Victim of domestic violence who is unable to obtain housing <input type="checkbox"/> Other (please explain): _____
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Section 5. Income					
Sources (check all that apply): <input type="checkbox"/> SSI <input type="checkbox"/> VA <input type="checkbox"/> Unemployment <input type="checkbox"/> SSDI <input type="checkbox"/> Social Security <input type="checkbox"/> None <input type="checkbox"/> SDI <input type="checkbox"/> CalWORKS <input type="checkbox"/> Other (list below): _____ <input type="checkbox"/> GR <input type="checkbox"/> Wages/salary _____		Benefit Establishment Status (if applicable): Type of benefit: _____ Date Application Submitted ____/____/____ Pending Denied Appealed Type of benefit: _____ Date Application Submitted ____/____/____ Pending Denied Appealed			
Section 6. Desired Location					
Address of Unit Requested (if known):		Requested Service Area(s):			
Street Address _____	Unit/Apt. _____	<input type="checkbox"/> SA 1: Antelope Valley <input type="checkbox"/> SA 2: San Fernando/Santa Clarita Valleys <input type="checkbox"/> SA 3: San Gabriel Valley <input type="checkbox"/> SA 4: Metro <input type="checkbox"/> SA 5: West <input type="checkbox"/> SA 6: South <input type="checkbox"/> SA 7: East <input type="checkbox"/> SA 8: Harbor			
City _____	State _____			Zip _____	
Section 7. Household Size					
(attach additional page if necessary) <input type="checkbox"/> 1 person <input type="checkbox"/> 2 people <input type="checkbox"/> 3 people <input type="checkbox"/> 4 people <input type="checkbox"/> Other _____					
If more than one person is checked above, complete the following:					
Name: _____	Name: _____	Name: _____			
Relationship: _____	Relationship: _____	Relationship: _____			
Date of Birth: _____	Date of Birth: _____	Date of Birth: _____			
Age: _____	Age: _____	Age: _____			
Signed Authorization to Disclose Client's Protected Health Information attached <input type="checkbox"/> Yes <input type="checkbox"/> No					
This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Codes, Civil Codes and Health Information and Portability Act (HIPPA) Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.					
Applicant Signature _____		Signature of Representative from Referring Agency _____			
Date _____		Date _____			
Send to: Department of Mental Health Housing Policy & Development Attn: Housing Coordinator 695 S. Vermont Ave, 10th floor Los Angeles, CA 90005 fax (213) 637-2336					