County of Los Angeles - Department of Mental Health
Countywide Housing, Employment and Education Resource Development
Federal Housing Subsidies Unit

HACoLA HCVP / REGULAR SECTION 8 APPLICATION COVERSHEET & CHECKLIST - (rev. 04/13/16)

Client Name:_____ SS#:_____

Name of Agency: DMH /_____ Service Area: _____ Supr. District _____

Housing Liaison:_____ Case Manager:_____

Housing Liaison Phone #:_____ Case Manager Phone #:_____

Housing Liaison Fax #:_____ Case Manager Fax #:_____

Housing Liaison Email:_____ Case Manager Email:_____

The following forms are required for every applicant under the Section 8 Homeless Program. In order for the Housing Authority to expedite the process of reviewing and approving your referrals, please complete all forms thoroughly. Place a check mark next to those documents included in this application packet and arrange forms in the following order:

_____ 1. HACoLA HCVP / Regular Section 8 Coversheet and Checklist (DMH form)
_____ 2. Housing Intake and Needs Assessment, 3 pgs (DMH form)
_____ 3. MH 677 HACoLA – Authorization for Use/Disclosure of PHI, 2 pgs (DMH form)
_____ 4. LACDMH Notice of Privacy Practices: **Acknowledgement of Receipt**, 1 pg (DMH form)
_____ 5. Authorization to Release Information
_____ 6. HCVP Service Provider Responsibility Form, 2 pgs (DMH form)
_____ 7. Affordable Care Act Certification Form (DMH form)
_____ 8. McKinney Vento Act Notice – Acknowledgment of Receipt (DMH form)
_____ 9. HACoLA Application for Rental Assistance: LA County Section 8 Housing Choice Voucher Program (HCVP), 41 pgs (This packet is not on the web; it is emailed to the case manager by FHSU)
_____ 10. Verification of Income
_____ 11. Identification Documents
___ Copy of CA ID/DL for **each** household member age 18 or older
___ Copy of signed Social Security Card for **each** household member
___ Copy of Birth Certificate for **each** household member

County of Los Angeles - Department of Mental Health
Countywide Housing, Employment, and Education Resource Development

HOUSING INTAKE AND NEEDS ASSESSMENT

Date of Assessment

Housing History:

What is client's current living situation?

☐ Motel ☐ Board and Care ☐ Streets, car, parks ☐ Transitional residential program
☐ Sober living home ☐ Friends/family ☐ Homeless shelter
☐ Apartment/SRO ☐ Other _____

Specify name or closest street: _____

Length of time in current situation? ☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ 12 months or longer

How many people does client live with? _____

Who does client live with? _____

Does client share a room? ☐ Yes ☐ No If yes, with whom? _____

Does client pay rent? ☐ Yes ☐ No If yes, how much? _____

Does client have a key? ☐ Yes ☐ No Does client's unit have running water/electricity? ☐ Yes ☐ No

Does client have access to bathroom and cooking facilities? ☐ Yes ☐ No

What kind of agreement does client have to live there? (lease/informal agreement)

_____

Financial Situation:

What is client's total monthly income? _____

Source of Income: ☐ SSI ☐ GR ☐ VA ☐ SSDI ☐ SDI ☐ CALWORKs/TANF
☐ Food Stamps ☐ Child Support ☐ Employment ☐ Other (such as family support)
☐ Unemployment Insurance ☐ None

Is income expected in the future? ☐ Yes ☐ No If yes, how much? _____

Does client have a payee? ☐ Yes ☐ No Does client have a savings/checking account? ☐ Yes ☐ No

Has client ever served in the United States Military? ☐ Yes ☐ No

Is client eligible for Military/Veterans benefits? ☐ Yes ☐ No

Transportation:

Does client own a vehicle? ☐ Yes ☐ No Does client use public transportation? ☐ Yes ☐ No

Criminal Convictions:

	Client:	Other Household Members:	Date of Conviction:
Drug-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Production/manufacture of Methamphetamine?	☐ Yes ☐ No	☐ Yes ☐ No	
Violence-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Registered as a sex offender?	☐ Yes ☐ No	☐ Yes ☐ No	
Arson?	☐ Yes ☐ No	☐ Yes ☐ No	

Print Client Name _____ IS # _____

DMH /

Agency/Program

Independent Living Supports/Assistance Needed:

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

Housing Plan:

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

Who will live with the client? _____

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

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

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

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

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

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

If yes, what accommodations? _____

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

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

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

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

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

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

☐ Homeless Section 8 ☐ Shelter Plus Care (SPC) ☐ Section 8 ☐ Project Based Section 8/SPC housing

If yes, complete the questions on the following page:

_____ _____

Print Client Name IS #

DMH / _____

Agency/Program

Shelter Plus Care (SPC) or Homeless Section 8 Eligibility Assessment *(Only Complete If Applicable)*:

Does the client meet HUD homeless criteria (reside in a place not fit for human habitation such as the streets, a park, a car, abandoned buildings, etc., an emergency shelter, transitional housing for clients who originally came from the streets or an emergency shelter, any of these but is spending a short time in a hospital or other institution, residing in a hospital or institution longer than 30 days if there is no discharge plan and the person would be homeless upon discharge, living in a private dwelling and be within one week of a sheriff's eviction with no resources or subsequent residence identified)?

☐ Yes ☐ No

Has the client been HUD homeless for a continuous year or longer? ☐ Yes ☐ No

Has client ever been evicted from a Governmental subsidized housing program (Sec. 8, SPC etc.)? ☐ Yes ☐ No

If client is currently homeless, how many episodes of HUD homelessness has s/he had in the last three years?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Is client a US citizen or legal resident? ☐ Yes ☐ No

Does client reside in:

A place not meant for human habitation such as the streets, a car, abandoned buildings, parks, bus stations, doorways, etc.? ☐ Yes ☐ No

A homeless shelter? ☐ Yes ☐ No

Transitional or supportive housing for homeless persons who originally came from the streets or a homeless shelter? ☐ Yes ☐ No

Any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution and would otherwise sleep in the types of places described above? ☐ Yes ☐ No

A hospital or institution longer than 30 days if there are no resources available or discharge plan in place and the individual will be homeless when discharged? ☐ Yes ☐ No

A private dwelling and be within one week of a Sheriff's eviction (has eviction papers) with no subsequent residence identified, and lacks the resources and support networks to obtain housing? ☐ Yes ☐ No

Is client fleeing from domestic violence? ☐ Yes ☐ No

Shelter Plus Care is designed for clients who need intensive supportive services such as those in Full Service Partnerships (FSP).

Is the client expected to receive approximately $12,000/yr. worth of ongoing supportive services for at least 5 years? ☐ Yes ☐ No

If the client wants to apply for Homeless Section 8:

Will s/he be receiving supportive services for at least 1 year after lease up? ☐ Yes ☐ No

Is client willing to have at least 4 housing visits in the 1st year of occupancy? ☐ Yes ☐ No

What is the client's housing goal? _____

What have been/are barriers to permanent housing? _____

What are the steps/plan to help client achieve housing goal (include how barriers will be addressed)?

_____

_____

_____

_____

_____ _____

Print Client Name IS #

DMH / _____

Agency/Program

Provider Signature: _____ Client Signature: _____

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

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

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

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	**Last Name**
Street Address	**City, State, Zip**
IS Number	**Birth Date**
	( ) Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Housing Authority of the County of Los Angeles (HACoLA), Special Needs Housing Unit.

REDISCLOSURE NOTICE:

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

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

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

Purpose of Disclosure:

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

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

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

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

N O T I C E

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

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

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

EXPIRATION DATE

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

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

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

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

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

REVOCATION OF AUTHORIZATION

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

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

LAC-DMH NOTICE OF PRIVACY PRACTICES: *Acknowledgement of Receipt* Effective Date: September 23, 2013

TRANSLATION ☐ NO ☐ YES

This Acknowledgement was translated into _____ for the client and /or responsible adult*

_____ _____
PRINT NAME OF TRANSLATOR DATE

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County - Department of Mental Health (LAC-DMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-DMH**.**

Signature: _____ Date:_____
(Client/Responsible Adult)

*Responsible Adult = Guardian, Conservator, or Parent of Minor when required (See Minor Consent)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member:_____ Date:_____

Reasons why the acknowledgement was not obtained:

- ☐ Client refused to sign (see progress notes for explanation)
- ☐ Other Reason or Comments:

_____

_____

_____

_____

_____

_____

Los Angeles County –Department of Mental Health
Notice of Privacy Practices

Effective: **September 23, 2013**

NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING /PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting your information. We refer to this information as "Protected Health Information" or "PHI". We create a record of the care and services you receive from Los Angeles County-Department of Mental Health ("LAC-DMH"). We need this record to provide you with quality care and to comply with certain legal and payment requirements.

This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning your PHI; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

We use and disclose PHI in many ways. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories required by law.

For Treatment We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, nursing and medical students, or LAC-DMH personnel who are involved in taking care of you. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some medications may affect your blood pressure. We may share your PHI for treatment in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

For Payment We may use and disclose PHI about you so that the treatment and services you receive at LAC-DMH may be billed and payment may be collected from you or on your behalf from an insurance company or a third party. For example, we may need to give your health plan information about testing that you received at our facilities so your health plan will pay us or reimburse you for those services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose PHI about you for our LAC-DMH business operations. These uses and disclosures are necessary to run our organization and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also gather PHI about many of LAC-DMH clients to decide what additional services our facilities should offer, what

services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, nursing and medical students, and other personnel for review and learning purposes. We may also compare the PHI we have with PHI from other organizations and providers to determine how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the identify of any clients.

For Appointment Reminders We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at LAC-DMH clinics.

For Your Own Information We may use and disclose PHI to tell you about your own health condition, such as your test results, to tell you about or recommend possible treatment options or alternatives, and to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care We may disclose PHI about you to a family member or other person you designate if you give us permission to do so. We may also tell certain family members about your presence in our facility but only if the law permits us to do so. We may share PHI about you when necessary for a claim for aid, insurance, or medical assistance to be made on your behalf.

For Health Information Exchange (HIE)We, along with other health care providers in the Los Angeles area, participate in one or more health information exchanges. An HIE is a community-wide information system used by participating health care providers to share health information about you for treatment purposes. Should you require treatment from a health care provider that participates in one of these exchanges who does not have your medical records or health information, that health care provider can use the system to gather your health information in order to treat you. For example he or she may be able to get laboratory or other tests that have already been performed or find out about the treatment that you have already received. We will include your PHI in this system.

For Research

Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process, but we may, disclose PHI about you to people preparing to conduct a research project, for example, to help them look for clients with specific medical needs. We will always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law We will disclose PHI about you when required to do so by federal, State or local law, such as laws that require us to report abuse.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Provide Breach Notification We may use and disclose your PHI, if necessary, to tell you and regulatory authorities or agencies of unlawful or unauthorized access to your PHI. For example, if your PHI is lost or stolen.

SPECIAL SITUATIONS WHEN WE MAY USE OR DISCLOSE PHI/PHI ABOUT YOU:

Workers' Compensation We may release PHI about you for workers' compensation or similar programs to comply with these and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose PHI about you when required for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of product recalls of the products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect We may disclose PHI about you to a public health authority that is authorized by law to receive reports of child abuse or neglect. We may also disclose your PHI if we believe that you have been a victim of elder or dependent adult abuse or neglect provided the disclosure is authorized by law.

Lawsuits and Dispute If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the privacy of the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- in response to a court order, court-issued subpoena, court- issued warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization;
- about criminal conduct at LAC-DMH facilities; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

Protective Services for the President and Others We may disclose PHI about you to authorized federal or government law enforcement officials so they may provide protection to the President, other authorized or elected persons or foreign heads of state or to conduct special investigations.

Protection and Advocacy Services We may disclose PHI about you to the protection and advocacy agency established by law to investigate incidents of abuse and neglect and to otherwise protect the legal and civil rights of people with disabilities.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official we may disclose PHI about you to the correctional institution or law enforcement official. This disclosure would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your PHI that is used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the facility where you are receiving treatment/services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If your health information is available electronically, under certain circumstances, you may be able to obtain this information in an electronic format. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to PHI, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by LAC-DMH will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

Right to Amend If you feel that PHI we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all of the information, both old and new, is kept by or for LAC-DMH. To request an amendment, your request must be made in writing and submitted to the LAC-DMH facility where the information is in question. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- is not part of the PHI kept by LAC-DMH;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you, excluding disclosures for the purpose of treatment, payment or healthcare operations. To request this list or accounting of disclosures, you must submit your request in writing to LAC-DMH or we will provide you with a form to make your request. Your request must state a time period, which may not be more than six years prior to your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12- month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member. We will do our best to honor your request; however, except when you fully pay out-of-pocket as explained below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing or we will provide you with a form to make your request. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right To Restrict Disclosure of Information For Certain Services You have the right to restrict the disclosure of information regarding services for which you or someone else has paid in full or on an out-of-pocket basis (in other words you don't ask us to bill your health plan or health insurance company). If you or someone else has paid in full for a service, we must agree to your request and we will not share this information with your health plan without your written authorization, unless the law requires us to share your information.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to LAC-DMH or we will provide you with a form to make your request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to honor your request.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any of our office staff. You may obtain a copy of this Notice at our website: http://dmh.lacounty.gov/

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or you may request one from one of our facilities.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the U.S. Department of Health & Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, please contact:

Los Angeles County Department of Mental Health (LAC-DMH)
Patients' Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020
(213) 738-4949

To file a complaint with Los Angeles County, contact:

Los Angeles County Auditor-Controller
HIPAA Compliance Unit
500 West Temple Street, Suite 515
Los Angeles, CA 90012
(213) 974-2164
Email: HIPAA@auditor.lacounty.gov

To file a complaint with the Federal Government, contact:

Region IX, Office for Civil Rights,
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (800) 537-7697

Authorization to Release Information

CLIENT #: _____

I authorize the Housing Authority of the County of Los Angeles (HACoLA) to release any requested information, to provide copies of any documents contained in my file, and to discuss any topic relevant to my application for or participation in a HACoLA assisted housing program with the following and their agents or employees. This authorization form is valid throughout the duration of my participation in the HACoLA assisted housing program.

☐ Los Angeles County Department of Mental Health

☐ Other (please name): _____

Client's Name: _____

Client's Signature: _____

Date: _____

(04/2016)

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

HACoLA HOUSING CHOICE VOUCHER PROGRAM (HCVP)
SERVICE PROVIDER RESPONSIBILITY FORM

To be completed and signed by the Program Agency Manager:

Name of Participant: _____

Name of Agency: DMH / _____

The program manager will ensure that the HCVP participant will have an assigned case manager who will be responsible for the following for the duration of client participation in the program:

- Assist the client with completing the required documents by the Housing Authority of the County of Los Angeles (HACoLA).
- Assist the client in a housing search.
- Send signed lease agreements to the Federal Housing Subsidies Unit (FHSU) when received.
- Ensure that the agency remains updated regarding participant's current contact information.
- Maintain, at a minimum, monthly contact with the participant and quarterly home visits.
- Conduct needs assessments to determine appropriate linkage to community-based services such as health care, childcare, alcohol and other substance abuse, education and/or job training, and other services essential for achieving and maintaining independent living.
- Conduct ongoing assessments/evaluations to monitor progress and provide appropriate interventions as needed.
- Update the participant's Client Care Coordination Plan (CCCP) annually and include any appropriate housing-related goals.
- Submit signed MH 677, Authorization for Request and Use/Disclosure of Protected Health Information (PHI) to allow DMH to disclose PHI to the Housing Authority (MH 677 HACoLA) and a signed MH 601E, Acknowledgement of Receipt of the LACDMH Notice of Privacy Practices.

- Comply with all requirements of McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.) including that they ensure and monitor that households with school-aged minors are enrolled in school and receive entitled benefits.

- Participate in regularly scheduled Housing Liaison meetings to obtain updates on program requirements.

Print Program/Agency Manager's Name: _____

Program/Agency Manager's Signature: _____

Date: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

AFFORDABLE CARE ACT CERTIFICATION FORM

To be completed and signed by the Case Manager:

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

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

Name of Participant: _____

Name of Agency: DMH / _____

Print Case Manager's Name: _____

Case Manager's Signature: _____

Date: _____

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

ACKNOWLEDGEMENT OF RECEIPT
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

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

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

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

Los Angeles County Office of Education Website:
http://www.lacoe.edu/StudentServices/HomelessFosterYouth/HomelessChildren

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

Los Angeles Unified School District (LAUSD):

LAUSD Web site
http://homelesseducation.lausd.net/

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

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

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

_____ _____
Signature Date

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

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

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

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

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

Los Angeles County Office of Education Website:

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

Los Angeles County Office of Education Contact

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

Los Angeles Unified School District (LAUSD):

LAUSD Web site

http://homelesseducation.lausd.net/

LAUSD Contact

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

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

You can ENROLL in school!

Even if you have:

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

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

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

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

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

You may:

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

Parents' responsibilities are to:

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

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

Your local school district liaison:

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

Your county liaison for the homeless:

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

Your state coordinator for the homeless:

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

California Department of Education

PLACE HERE

HACoLA APPLICATION FOR RENTAL ASSISTANCE: LA COUNTY SECTION 8 HOUSING CHOICE VOUCHER PROGRAM (41pgs)

The Federal Housing Subsidies Unit (FHSU) emails this packet directly to the DMH Housing Liaison / Case Manager.

For more information, please contact:

Jessica Jones-Montgomery
@ 213-251-6560
(jjonesmontgomery@dmh.lacounty.gov)

PLACE HERE

INCOME VERIFICATION including the following:

- Verification of Employment and Earnings (3 months of pay stubs) (if applicable)
- Verification of DPSS Assistance (Notice of Action)
- Verification of Social Security Benefits
- Unemployment / State Disability Insurance Award Letter & 3 consecutive check stubs
- Child Support Payment History Chart & 3 consecutive check stubs
- Adoption / Foster Care / Kin-Gap Assistance Payment Letter
- Self-Employment – all pages of most recent year Tax Returns, W'2s & 1099s
- Bank Verification of Income and Assets (1 month bank statement) *for* ***every*** *household bank account*
- Verification of Contributions Received
- Retirement Income Verification Letter
- Life Insurance
- Pension / Annuity Award Letter

PLACE HERE

Copy of each household member's California Identification Card (ID) or Driver's License. **If the CA ID/DL expires before the client is housed, the application will be withdrawn;** therefore, if the ID/DL is within 6 months of expiration, ask the client to renew their ID at the DMV. Submit a copy of the DMV application/receipt with the HACLA application.

-and-

Copy of each household member's **signed** Social Security Card. If it is not signed, the application will be returned to the clinic/agency that submitted it.