COUNTYWIDE BENEFITS ENTITLEMENTS SERVICES TEAM (CBEST)
REFERRAL FORM

LA COUNTY Homeless Services & Housing

Referral Date: _____

PRE-SCREENING: CBEST PROGRAM ELIGIBILITY*			
Is the client interested in applying for SSI, SSDI, CAPI? ☐Yes ☐No			
Is the client currently Homeless or At Risk of Homelessness (Please check ONE below) Homeless (currently NOT housed) ☐Yes Total # of mos. homeless ____ At risk of homelessness (currently housed) ☐Yes ☐No			
CLIENT IDENTIFYING INFORMATION			
First Name:	**Middle Name:**	**Last Name:**	
Aliases:	**SSN:**	**Birthplace:**	**DOB:**
CLIENT CONTACT INFORMATION			
Mailing Address:			
Frequent Location (if no address)**:**			
City:	**State:**	**SPA:**	**Zip:**
Primary Phone:	**Alt Phone:**	**Email:**	
INITIAL SCREENING OF CLIENTS FOR SSI, SSDI, CAPI BENEFITS ELIGIBILTY			
Has the client applied for SSI or SSDI before as an adult (18+)?			
☐Yes ☐SSI (Date of application): _____ ☐SSDI (Date of application): _____ ☐No	**Disposition:** ☐Approved ☐Pending ☐Denied; if so, when?_____: if appealed, when?_____ ☐Unknown		
Has the client served in the U.S. Armed Forces)? ☐Yes ☐No			
Has the client been incarcerated in the last year? (Response does not affect eligibility) ☐Yes ☐No			
Is the client a US Citizen? (Response does not necessarily affect eligibility) ☐Yes ☐No **If no, does the client have proof of their lawful immigration status?** ☐Yes ☐No **If yes, please check below what proof the client has and provide the status of the document:** ☐Lawful Permanent Resident (LPR)/Green Card ☐Current ☐Expired (exp date:_____) ☐Other:_____ ☐Visa ☐Current ☐Expired (exp date:_____) ☐Other:_____ ☐Work Permit ☐Current ☐Expired (exp date:_____) ☐Other:_____ ☐Other/Pending: _____ ☐Current ☐Expired (exp date:_____) ☐Other:_____			

What is/are the main health impairment(s) expected to last 1+ year that client feels makes them unable to work? Physical Health: _____ Is the client currently receiving treatment for physical allegations listed above? ☐Yes ☐No Mental Health: _____ Is client currently receiving treatment for mental health allegations listed above? ☐Yes ☐No	
What is the client's language preference(s)?	
REFERRER INFORMATION	
Referring Agency and/or Facility	
Referrer Name:	**Referrer Title:**
Referrer Phone:	**Referrer Email:**
Referrer Special Remarks:	
Is this an outreach team referral? ☐Yes ☐No	

Please send the referral to HSH CBEST Admin Team via: CHAMP ID#: _____

Email: cbestreferral@hsh.lacounty.gov (NOTE: New email as of Jan. 1, 2026)

Fax: (323) 389-4322

rev. 1.2026

**Please note: The information contained herein reflects eligibility criteria for the CBEST Program ONLY and does not reflect eligibility criteria from the Social Security Administration. The information in this document is not intended to convey or constitute legal advice on potential eligibility for government benefits.*