HACoLA HCV plus D7 Supportive Services

Check List Cover Sheet

Check List Cover Sheet:

- ☐ CES Participant HMIS number: _____
- ☐ HACoLA Housing Choice Voucher Section 8 Program – Waiting List Homeless Preference Referral Form
- ☐ Business card of referring party/entity with agency address
- ☐ Housing for Health Authorization for Use and Disclosure
- ☐ Housing for Health Authorization to Release/Share Information
- ☐ Housing for Health Housing Referral Form *(highlighted items only)*
- ☐ DMH Authorization For Release or Disclosure of Protected Health Information Form *(for DMH clients only)*
- ☐ Rapid Re-housing Program Justification of PSH Need *(for rapid re-housing clients only)*

Instructions for submission:

- ☐ Scan and send all forms to your CES SPA Matcher, *including this Cover Sheet with HMIS number*
- ☐ Title email **"HACoLA Vouchers plus D7"**

Instructions for completing HACoLA Housing Choice Voucher Program – Waiting List Homeless Preference Referral Form:

- The **top section** should be filed out by the referring agency.
  - For SPA CES Coordinator and Email, please include the name and email contact of for your CES SPA Matcher.
- The **middle section** should be filled out by the CES Participant. CES Participant must check off the two boxes and sign and date. *Boxes must be check and client signature must be included, or the referral will not be accepted.*
- The **bottom section** will be completed and signed by LAHSA staff, upon receipt from the SPA CES Matcher.
- *If a copy of the referring party/entity business card is not included, the referral will not be accepted.*

Housing Authority of the County of Los Angeles
P.O. Box 1510 • Alhambra, CA 91802

HOUSING CHOICE VOUCHER PROGRAM - WAITING LIST HOMELESS PREFERENCE REFERRAL FORM

Supportive Services Agency Completes this Section (Attach Business Card):

Client Name: ______________________ Agency Phone Number: ______________________

Name of Agency: ______________________ Service Planning Area (SPA): ______________________

Agency Contact: ______________________ SPA CES Coordinator: ______________________

Agency E-Mail Address: ______________________ SPA CES E-mail: ______________________

Client Completes this Section:

Starting with the head of household, please complete this table for all family members who will reside in the household. Attach additional sheet if necessary.
RELATIONSHIP CODE: H – Head of Household, S- Spouse, K- Co-Head, A- Other Adult, N- Son, D- Daughter, Y- Other Minor, L- Live-In Attendant, F- Foster Child, E- Foster Adult

HOUSEHOLD MEMBER NAME	RELATION (use codes)	GENDER (Male/Female)	RACE	ETHNICITY	SOCIAL SECURITY NUMBER	DATE OF BIRTH	ESTIMATED ANNUAL INCOME
	H	☐ M ☐ F	☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native	☐ Hispanic/Latino ☐ Not Hispanic/Latino			
		☐ M ☐ F	☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native	☐ Hispanic/Latino ☐ Not Hispanic/Latino			
		☐ M ☐ F	☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native	☐ Hispanic/Latino ☐ Not Hispanic/Latino			
		☐ M ☐ F	☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native	☐ Hispanic/Latino ☐ Not Hispanic/Latino			
		☐ M ☐ F	☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native	☐ Hispanic/Latino ☐ Not Hispanic/Latino			

☐ Check this box if any member of the household is a veteran or current member of the armed forces

☐ **By checking this box I authorize HACoLA to share the information provided with individuals and/or agencies listed on this form during the process of eligibility and participation in the Housing Choice Voucher Section 8 Program.**

Client Signature ______ Date ______ Printed Name ______ Phone Number ______ Email Address ______

Los Angeles Homeless Services Authority (LAHSA) Completes this Section:

☐ **By checking this box, the LAHSA representative is certifying that this person or family is homeless according to the definition set forth by HUD as outlined by the Memorandum of Understanding with HACoLA and came through the Coordinated Entry System (CES).**

LAHSA Signature ______ Date ______ Printed Name ______ Phone Number ______ Email Address ______

Staple

COUNTY OF LOS ANGELES

LOS ANGELES COUNTY + USC MEDICAL CENTER

DEPARTMENT OF HEALTH SERVICES

Last Name | First | Date of Birth (Mo/D/Yr) | Medical Record #

Address | City | State | Zip Code | ( ) Phone #

HEREBY AUTHORIZES:

☐ DEPARTMENT OF HEALTH SERVICES

☐ Other: _____

Facility Name | Street Address | City, State | Zip Code

To Release Protected Health information To:

Department of Health Services (DHS) Housing for Health Program.

TYPE OF RECORDS TO BE DISCLOSED

☐ Ambulatory Clinic Records	☐ Lab & Pathology Reports	☐ Emergency Department Records
☐ Progress Notes	☐ Discharge Summary	☐ Insurance Information
☐ History & Physical	☐ Operative Reports	☐ Imaging Reports
☐ HIV/AIDS Test Results		
☐ Other, specify:		

Housing for Health will obtain up to five (5) years of medical information unless otherwise specified:

_____ (Date/Timeframe)

The following information will only be released if you give your specific permission by providing your initials to the following:

_____ I agree to the release of information pertaining to mental health diagnosis or treatment that are otherwise protected under Welfare & Inst. Code 5328, excluding psychotherapy notes defined by 45 CFR 164.501

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)

T-LAC101422

FILE IN MEDICAL RECORD

THE PURPOSE OF THE DISCLOSURE IS: To permit Housing for Health and their contractors 1) to determine eligibility for Housing for Health resources; 2) to provide the minimum necessary protected health information to community based organizations, who are contracted with DHS to arrange for housing, case management and integrated and coordinated services; 3) to assist me in the application and receipt of any public benefit which I may be otherwise entitled to; and 4) to provide me with on-going case management services.

NOTICE

Department of Health Services and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentially laws.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- I understand this authorization is voluntary and will not affect my ability to obtain treatment. However, without a signed Authorization, DHS Housing for Health may not have adequate information to determine my eligibility for housing services.
- I am entitled to receive a copy of this Authorization.
- I may revoke this authorization at any time, provided that I do so in writing and may use the form below.
- The revocation will take effect when DHS receives it, except to the extent that DHS or others have already relied on it.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires five (5) years from the date of signing below.

AUTHORIZATION

I have had the opportunity to review this and understand what it says. By signing, I agree that it accurately reflects my wishes and I affirm that I have not place any restriction on the release of any information authorized for release by this Authorization.

_____ _____

Signature of Patient/Legal Representative Print Name

Date: _____/_____/_____

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

_____

Witness: _____

Print Name: _____

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)

T-LAC101422

Right to Revoke This Authorization – I understand that I may revoke this Authorization for Housing for Health at any time by giving written notice of my revocation to the DHS facility at the address listed below. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following address:

I also understand that a revocation will not affect the sharing of information done in reliance of this Authorization prior to it's being revoked.

REVOCATION OF AUTHORIZATION

Signature of Patient/Legal Representative: _____

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

_____

DATE: _____/_____/_____

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)

Health Services
LOS ANGELES COUNTY

HOUSING FOR HEALTH

Patient First & Last Name:_____ MRUN #_____

Housing for Health Authorization to Release/Share Information

I agree to allow the Department of Health Services (DHS) and/or HFH Service Partners (a provider that has a contract or agreement with Department of Health Services whom the department has deemed appropriate for the patient), to share my information with each other for the following purposes:

1. DHS and/or HFH Service Partners may use my information to provide me with case management, integrated and/or coordinated services, and to assist in providing temporary and/or permanent housing opportunities.
2. DHS and/or HFH Service Partners may use or disclose my information for research purposes, subject to the requirements of applicable law, and to make recommendations on policies to improve services for people experiencing homelessness.
3. I understand that if I sign this agreement, I voluntarily consent and hereby authorize DHS to release and disclose information about me to HFH Service Partners.
4. I understand that if I sign this agreement, I voluntarily consent and hereby authorize HFH Service Partners to release and disclose information about me to DHS.
5. I understand and agree that I will receive no money or other benefits from the County of Los Angeles, DHS, HFH Service Partners or any other party as a result of consenting to the release of such information.
6. I agree to release the County of Los Angeles, DHS, HFH Service Partners, its agents and employees from any liability whatsoever, including for injuries, damages and losses, known or unknown, resulting from sharing the information with other County departments, homeless service providers and housing locators, with whom the County has relationships.
7. I acknowledge that before signing this consent for release agreement, I have carefully read and fully understand its terms. If I am unable to read, the person asking me to sign this form has read and explained all of the items/terms listed in this agreement.
8. This agreement shall become effective on the date provided below and will **expire one year** from the date below.

_____
Date

_____ _____
Applicant Signature Referring Staff Signature

_____ _____
Print Applicant Name Print Referring Staff Name

HOUSING FOR HEALTH (HFH) HOUSING REFERRAL FORM

Date: _____

Referring Agency/DHS Facility:	**Staff Name/Title:**
Office #:	**Cell/Pager #:**
Alternate Staff:	**Office/Pager #:**

IDENTIFYING INFORMATION

First Name:	**Middle Name:**	**Last Name:**

Know Aliases:	**SSN#**	**Mother's Maiden Name:**	**Place of Birth:**

DOB:	**Client ID#**

Gender:		**Marital Status:**	
□ Male	□ Other	□ Single	□ Common Law
□ Female	□ Client Doesn't know	□ Never Married	□ Living Together
□ Transgender (F to M)	□ Client Refused	□ Divorced	□ Widowed
□ Transgender (M to F)	□ Data Not Collected	□ Married & Living with Spouse	□ Other
		□ Married & Not Living with Spouse	□ Civil Union

FAMILY INFORMATION

Relationship to Head of Household:

□ Self	□ Dependent Child	□ Other Family Member
□ Parent	□ Grandparent	□ Other Non-Family
□ Son	□ Guardian	□ Other Caretaker
□ Daughter	□ Spouse	

Contact Information: If you do not enter a phone number of email address, you willl be required to provide a contact plan during the application process.

Mailing Address:		
Address 2:		
City	State	Zip Code
Service Planning Area:	Different Residential Address:	
Primary Phone:	Alternate Phone:	Email Address:
Frequent Client Location :	Other Contact Information:	

DEMOGRAPHIC INFORMATION

Ethnicity	**Race**	
□ Hispanic/Latino	□ American Indian or Alaska Native	□ White
□ Non-Hispanic/Latino	□ Asian	□ Client Doesn't Know
□ Client Doesn't Know	□ Black or African American	□ Client Refused
□ Client Refused	□ Native Hawaiian or Other Pacific Islander	□ Data not Collected
□ Data Not Collected		

Have you served in the US armed forces?

□ Yes	□ Client doesn't know	□ Data not collected
□ No	□ Client refused	

Primary Language

English	Other:	Can communicate in English? □ Yes □ No

CITIZENSHIP INFORMATION

Citizenship Status:

□ U.S. Citizen	**Country of Origin:**
□ Eligible Non-Citizen	**Alien Number:**
□ Ineligible Non-Citizen	**Entry Date:**

APPLICATION FAMILY COMPOSITION

First Name:	**Last Name**	**Gender**	**DOB**	**DOB Quality**	**Relationship to Head of Household**

MULTIPLE INTERESTED OTHERS					
Type	**Relationship**	**Name**	Primary Phone	Email Address	Note

SERVICE ANIMALS						
Name	Animal Type	Weight (in lbs.)	Need Type	History of Aggression	Vaccination	Additional Information

REQUIRED DOCUMENTS	
Authorization to Release/Share information	**Authorization for Use and Disclosure of PHI**
□ Signed Document	□ Signed Document
Method of Verification: □ Scanned Uploaded	Method of Verification: □ Scanned Uploaded
Comment:	Comment:
Date Signed:	Date Signed:

HOUSING DOCUMENTS					
Verification Date:					
Verification Item	**Acceptable Document**	**Method of Verification**	**Issuance Date**	**Expiration Date**	**Comment**
Birth Certificate	□ Birth Certificate	□ Scanned Uploaded			
Valid Government ID	□ CA State ID	□ Scanned Uploaded			
	□ Consulate/International ID				
	□ Driver's License				
	□ Military Identitfication				
	□ Other State ID				
	□ Passport				
	□ Permanent Resident Card				
Social Security Card	□ Social Security Card	□ Scanned Uploaded			
Proof of Income	□ None				
	□ Paystub				
	□ Social Services/Income Verification				
	□ Tax Return				
	□ W2				
Proof of Residency	□ Document	□ Scanned Uploaded			

HOMELESS STATUS	
Assessment Date:	Current Location:
Service Planning Area:	Years Homeless: Months Homeless:
Geographic Preferences	**Geographic Restrictions**
□ Antelope Valley (SPA 1)	□ Antelope Valley (SPA 1)
□ Countywide (SPA 1 - 8)	□ Countywide (SPA 1 - 8)
□ Downtown (SPA 4)	□ Downtown (SPA 4)
□ Hollywood (SPA 4)	□ Hollywood (SPA 4)
□ East L.A. (SPA 4)	□ East L.A. (SPA 4)
□ San Fernando Valley (SPA 2)	□ San Fernando Valley (SPA 2)
□ San Gabriel Valley (SPA 3)	□ San Gabriel Valley (SPA 3)
□ South Bay/Long Beach (SPA 8)	□ South Bay/Long Beach (SPA 8)
□ Southeast (SPA 7)	□ Southeast (SPA 7)
□ South L.A. (SPA 6)	□ South L.A. (SPA 6)
□ West L.A. (SPA 5)	□ West L.A. (SPA 5)
□ Los Angeles (SPA 4 - 7)	□ Los Angeles (SPA 4 - 7)
Willing to Reside in Communal Living for Permanent Housing: □ Yes □ No	
Willing to Reside in Skid Row for Permanent Housing: □ Yes □ No	
History of Aggression: □ Yes □ No	**History of Domestic Violence:** □ Yes □ No
CES Package Completed? □ Yes □ No	**CES Package Score:**

HOMELESS QUESTIONNAIRE - Check the box next to each true statement

□ The client is an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: Has a primary nighttime residence that is a public or private place not meant for human habitation; OR is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs).

□ The client is an individual who is exiting an institution where he/she resided 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

□ The client is an individual or family who will imminently lose their primary nighttime residence within 14 days and no subsequent residence has been identified and the individual or family lacks the resources and support networks needed to obtain housing.

□ The client is an individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence; and lacks the resources or support networks to obtain other permanent housing.

□ The client has a disability, including but not limited to, a diagnosable substance use disorder, serious mental illness, severe chronic health condition (including AIDS), or the co-occurrence of two or more of these conditions.

□ The client has been homeless CONTINUOUSLY for at least twelve (12) months

□ OR on at least four (4) separate occasions* in the last three (3) years where the combined occasions must total at least twelve (12) months.

* Occasions are separated by a break of at least seven nights that an individual is not residing in an emergency shelter, safe haven, or a place meant for human habitation (e.g., staying with a friend, in a hotel/motel paid for by the program participant). Institutional stays of less than 90 days do not constitute a break.

FINANCIAL PROFILE

Assessment Date:

Type	Description	Monthly Amount
□ Employment		
□ Unemployment		
□ General Relief (GR)		
□ Supplemental Security Income		
□ Social Security Disability Insurance (SSDI)		
□ Veteran's Administration Benefits		
□ Food Stamps/Cal FRESH		
□ Other		

MEDICAL PROFILE

Assessment Date:

Insurance Information

Type	Insurance Provider Name	Is Primary	Status	Date Applied	Start date	End date
□ Medi-Cal		□	□ Pending /Applied □			
□ Medicare		□	□ Pending /Applied □			
□ Medi-Cal/Medicare		□	□ Pending /Applied □			
□ VA		□	□ Pending /Applied □			
□ Healthy Families		□	□ Pending /Applied □			
□ Private		□	□ Pending /Applied □			
□ Other		□	□ Pending /Applied □			
□ None		□	□ Pending /Applied □			
□ Unknown		□	□ Pending /Applied □			

Physical Health Information

Primary Care Provider	
Medical Facility/Clinic:	Medical Last Visit Date:
Chronic Conditions:	

Mobility/Accessibility Needs	
□ Cannot Climb Stairs	□ Needs Ramp Access
□ Has Manual Wheelchair	□ Uses Manual Wheelchair
□ Has Motorized Wheelchair	□ Uses Motorized Wheelchair
□ Needs Assistance Transferring In/Out of Wheelchair	□ Uses Walker/Cane/Crutches
□ Other	
	□ None

Medical Needs	
□ Activities of Dailiy Living (hygiene/grooming, etc.)	□ Independent Living Skills (cleaning, cooking, etc.)
□ Breathing (supplemental oxygen)	□ Taking Medications
□ Incontinent Issues	□ Other
	□ None

Mental Health Information	
Mental Health Clinician Name:	
Medical Health Agency/Clinic:	Mental Health Last Visit Date:

Mental Health Diagnoses	
□ Anxiety Disorder	□ Post-Traumatic Stress Disorder
□ Bipolar Disorder	□ Psychosis
□ Depression	□ Schizoaffective Disorder
□ Mood Disorder	□ Schizophrenia
□ Personality Disorder(Axis II)	□ Suicidal Ideation/Attemped Suicide
□ Other	
	□ None

Cognitive Impairments	
□ Dementia	□ Mutiple Issues
□ Developmental Disability	□ Traumatic Brain Injury
□ If Other, Please Explain:	
Mental Health Diagnoses Details:	
	□ None

Substance Use Profile				
Substance	**Other Substance**	**Past Use**	**Current Use**	**Date Last Use**
□ Alcohol		□ Yes □ No	□ Yes □ No	
□ Benzodiazepines		□ Yes □ No	□ Yes □ No	
□ Cocaine/Crack Cocaine		□ Yes □ No	□ Yes □ No	
□ Heroin/Opiates		□ Yes □ No	□ Yes □ No	
□ Injectable Drug Use		□ Yes □ No	□ Yes □ No	
□ Marijuana		□ Yes □ No	□ Yes □ No	
□ Methadone		□ Yes □ No	□ Yes □ No	
□ Metamphetamines		□ Yes □ No	□ Yes □ No	
□ Prescription Narcotics		□ Yes □ No	□ Yes □ No	
□ Synthetic Marijuana/Spice		□ Yes □ No	□ Yes □ No	
□ Other		□ Yes □ No	□ Yes □ No	

Legal Profile					
Conviction/Legal Issue	**Other Issue**	**County**	**Date**	**Arrest**	**Conviction Date**
□ Arson					
□ Production Metamphetamines					
□ Sex Offender					
□ Violent Crime					
□ Warrants					
□ Other 1					
□ Other 2					
□ Other 3					

Clear Entire Form

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

CLIENT:

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

AUTHORIZES:	**USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO**:
LA County Department of Mental Health (DMH)	Los Angeles Homeless Services Authority (LAHSA)
Name of Agency	Name of Health Care Provider/Other
	811 Wilshire Blvd., Suite 600
Street Address	Street Address
	Los Angeles, CA 90017
City, State ZIP Code	City, State ZIP Code

INFORMATION TO BE RELEASED:

☐ Assessment/Evaluation ☐ Psychological Test Results ☐ Diagnosis
☐ Laboratory Results ☐ Medication History/Current Medication ☐ Treatment
☐ Entire Record (Justify): _____
☑ Other (Specify): Information on HACoLA HCVP Waiting List Homeless Preference Referral Form and Housing Application, including documents for Criminal Background Check (CBC), that will be submitted to HACoLA

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

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

Method of delivery of requested records:
☐ Mail ☐ Pickup ☑ Electronic Device (CD, USB)

PURPOSE OF USE OR DISCLOSURE: (Check applicable category)

☐ Client Request
☑ Other (Specify): To assist client to obtain Permanent Supportive Housing

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

I understand that my Protected Health Information used or disclosed pursuant to this Authorization may no longer be protected by federal law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is used or disclosed, it may not be possible to recall.

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

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of Authorization - I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form.

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

Contact Person	Agency Name
Address	City, State ZIP Code

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

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

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

✘	✘
Signature of Client/Legal Representative	Date

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

✘

REVOCATION OF AUTHORIZATION

Name of Client

Signature of Client/Legal Representative	Date

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

Printed Name: _____

Relationship and Authority: _____