HEALTH SERVICES DIRECTOR

PUBLIC HEALTH DIRECTOR

597 Center Avenue, Suite 325
Martinez, California
94553-4675

PH 925 313-6124
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Shelter Plus Care Program
Application Cover Sheet

Name of Applicant: ______________________________ Date: __________

Referring Agency: ______________________________

County Mental Health Office: ______________________________

Case Management Provider: ______________________________

Address: ______________________________

Phone Number: ____________________ Fax Number: ____________________

e-mail address: ______________________________

Please mail completed applications and the requested documentation to:

Evan Smith
Shelter Plus Care Program
597 Center Ave., Suite 325
Martinez, CA 94553

Tel (925) 313-6762
Fax (925) 313-6761
esmith@hsd.co.contra-costa.ca.us

SHELTER PLUS CARE APPLICATION REQUIREMENTS

Along with the application form, the following documentation needs to be submitted in order for the applicant to be considered for the Shelter Plus Care Program.

I. **Disability Verification**. Please check all applicable disabilities, *and* submit the specified documentation for *at least one* of these conditions (for S+C eligibility, a disability must be of long continued and indefinite duration, and substantially impede the applicant's ability to retain housing such that without ongoing support services the individual would have difficulty managing the responsibilities of a lease and living independently in the community).

- Mental Illness. DSM IV / Axis I Diagnosis ____

  Required documentation: Letter or signed statement from a mental health clinician, or a copy of a mental status exam or relevant hospitatl records documenting DSM IV / Axis I diagnosis, and that their mental iillness has been of a chronic nature.

- HIV / AIDS.

  Required documentation: Letter of diagnosis from medical provider documenting HIV-related disability.

- Chronic Substance Abuse.

  Required documentation: Letter from substance abuse counselor documenting a DSM IV diagnosis, and substantiating the need for long-term supportive services in order for the applicant to be able to live in independent housing, along with other documentation which substantiates a disability related to substance abuse, such as concurrent mental health problems or chronic medical conditions related to their substance abuse.

II. **Verification of Homelessness**. Please provide the following:

- Homelessness Certification Form checked-off and signed by applicant and provider
- Additional documentation specified on Homeless Certification Form to verify applicant's homeless status (i.e., letter from shelter or transitional program, etc.)

III. **Income Verification** *(include documentation for all household members if applicable)* *

- If receiving public benefits, a copy of award letter or print-out from government agency documenting benefits received.
- If employed, recent pay stubs or a letter from employer stating hours, wages and start date.

IV. **Additional Documentation**:

- Signed consent/release form
- Signed Program Agreement and a copy of the current service/self-sufficiency plan
- Copy of Social Security Card (or Social Security Paperwork with SS# visible)
- Copy of state photo identification or DMV letter stating photo ID pending

V. **Additional Household Members** (if applicable)

- Copies for Social Security cards for each household member
- Income verification
- Copies of photo identification for each household member over age 18
- Copies of birth certificates for each child under 18 who will be living with applicant

Contra Costa County Shelter Plus Care

Program Application

I. APPLICANT INFORMATION

Name:	SS#:
Age:	Date of Birth:
Gender (M/F):	How can applicant be reached:
Phone/Message Phone:	Mailing Address:
Please indicate applicant's race and ethnicity (for HUD reporting purposes only): Place check mark next to all that apply.	
Race: • Caucasian • African-American or Black • Asian/Pacific Islander • Native American / Alaskan • Other:	Ethnicity: • Hispanic • Non-Hispanic • Other:

II. HOUSEHOLD COMPOSITION

Please identify everyone who will be living with applicant after receiving S+C certificate:

A. Other adult over the age of 18:

Name:	Relationship to Applicant:
SS#:	Gender (M/F):
Date of Birth:	

(Please note: picture ID, social security card and income verification must be provided with application.)

B. Children under age of 18 that will be living with you (attach copy of birth certificates and SS cards):

Name	Sex	Age	Date of Birth	In School (Y/N)	CPS
1.					
2.					
3.					
4.					
5.					

C. With whom and where are each of the children currently residing?

1.
2.
3.
4.
5.

D.

Does applicant anticipate any changes to their household over the next 12 months? Answer Y/N:	If yes, for what reason? Check below:
• Birth of a child.	Due date:
• Reunification with children	
• Reunification with partner	
• Other:	

III. HOUSEHOLD INCOME

Please list sources of income for all household members:

Source of Income	Monthly Amount Received by Applicant	Income for other Household Member Name:	Income for other Household Member Name:
SSI			
SSDI			
SSDI			
General Assistance			
AFDC/TANF			
Food Stamps			
Unemployment Benefits			
Veterans Benefits			
Child Support / Alimony			
Employment			
• Name of employer			
• No. of hours/week			
Other:			

Health Insurance Coverage (place check in appropriate box):

Medical	Medicare	Private insurance	None

Is the applicant a veteran (Y/N)?

IV. HOUSING HISTORY

A	How long has applicant lived in Contra Costa County?	Answer:
B	Please describe current living situation and length of time there:	Answer:
C	What was applicant's living situation prior to this?	Answer:
D	Has applicant ever had their own apartment? If yes, how long ago? How long did they live there? Why did they leave?	Answer (Y/N): Answer: Answer: Answer:
E	Does applicant have any record of eviction or credit problems which would affect their ability to find housing with a S+C certificate?	If so, please explain and give reasons for any evictions:
F	Does applicant have an outstanding debt to any public housing authority?	Answer (Y/N): *If yes, an application should not be submitted to the Shelter Plus Care Program until the debt has been paid in full. (HACCC cannot issue a subsidy when there is an outstanding debt.)*

V. HEALTH HISTORY

A	Does applicant have a history of chronic drug or alcohol use? *[If no, skip to Question B]* • Drugs of Choice: • Is the applicant currently receiving counseling or treatment? • If yes, please describe (and list providers in Section VII):	Answer (Y/N): 1. 2. 3. Answer (Y/N): Answer:
B	Does applicant have any history of psychiatric problems? [If no, skip to Question C] • Is applicant currently taking prescribed psychotropic medication? • If yes, what medications: • Prescribing Psychiatrist:	Answer (Y/N): Answer (Y/N): Answer: Answer:
C	Has applicant tested positive for HIV? • If yes, does applicant have disabling condition related to HIV / AIDS? • Is applicant currently taking HIV_related medications? *Please identify primary care provider in Section VII*	Answer (Y/N): Answer (Y/N): Answer (Y/N):

VI. SUMMARY OF ABILITIES AND SERVICE NEEDS

A	**History of substance abuse, mental illness, HIV/AIDS:** How long has the applicant been affected by the disability? Has s/he ever been admitted to a hospital, residential treatment program(s) and/or psychiatric facility to address the disability? Does the applicant have any recent history of suicidal or violent behavior?	
B	**Current Status:** Describe how the applicant currently manages any mental health and addiction issues. Does the applicant appear to be able to maintain a sufficient support system and appropriate interpersonal relationships to successfully live independently?	
C	**Life Skills:** Please discuss the applicant's ability to manage the responsibilities of independent living, such as paying bills on time every month, maintaining their personal hygiene, household chores, food shopping, managing medications, keeping appointments, etc.	
D	**Current health needs:** Does the applicant have any special health-care needs? Do they have a regular primary care provider?	
E	**Service Needs:** Please highlight any particular service needs the applicant may have in order to manage the responsibilities of a lease and live in their own apartment, and indicate whether these supports are in place or will need to be identified.	

VII. SUPPORT SERVICES

Who will be the primary contact/service coordinator for the client while they are a participant in the Shelter Plus care Program?

Name:	Agency:	Phone:

Please identify other services that applicant is currently receiving:

Relationship	Agency/Phone	Name of Provider	Average Frequency of Contact	When did client begin services?
Case Manager: *(if not same as above)*				
Substance Abuse Counselor:				
Therapist / Mental Health Provider:				
Primary Care Provider:				
Housing Advocate:				
Money Management:				
Probation or Parole Officer:				
Other:				
Other:				

Please have the applicant sign the release form on the next page.

Refer to page 2 to make sure that all of the necessary documentation is included when you submit this form.

Thank you.

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SHELTER PLUS CARE PROGRAM
CONSENT TO RELEASE INFORMATION

I, ____. authorize the referring agency, ____, to release the information contained in the Shelter Plus Care Program Application to the Contra Costa County Shelter Plus Care Program staff.

In addition, upon approval of my application to the Shelter Plus Care Program, I authorize the release of information between the Shelter Plus Care Program, the Contra Costa Housing Authority, and the staff of ____ (name of case management agency).

I understand the information will be shared only for the purposes of coordinating services and administering the housing assistance provided through the Shelter Plus Care Program. I understand that this information is confidential and will not be released to other parties without my written permission.

The release will expire upon my exit from the Shelter Plus Care Program, unless I give the Shelter Plus Care Program written notice that I have decided to revoke this authorization.

Signature: ____ *Date:* ____________________

Witness/ Signature: ____ *Date:* ____________________

SHELTER PLUS CARE PROGRAM
CERTIFICATION OF HOMELESSNESS

In order to qualify for Shelter Plus Care, the applicant must meet HUD's definition of homelessness according to one of the following categories. Please check the applicable situation and provide the required documentation.

(Please note: if the applicant does not meet the following criteria, then an application should not be submitted. If uncertain about an applicant's eligibility, please contact the S+C Coordinator,)

	Streets or other place not fit for human habitation (i.e. park, abandoned car, homeless encampment). *(Documentation required: Letter from service provider on agency letterhead describing applicant's current living situation.)*
	Emergency Shelter. Name of Shelter: *(Documentation required: Confirmation letter on letterhead from shelter staff.)*
	Graduating from a residential treatment program with no other resources to obtain housing. *(Documentation required: Confirmation letter on program letterhead with date of entry and verifying that applicant currently resides there and has no housing available upon discharge.)*
	Leaving a transitional housing program specifically designed for homeless individuals and upon leaving has no resources to obtain housing. *(Documentation required: Confirmation letter on transitional program letterhead with date of entry and verifying that applicant currently resides there and has no housing available upon discharge.)*
	Being discharged from a hospital, and hospitalized for less than 30 days following residence on the streets or in emergency shelters. Upon leaving has no resources and support network to obtain housing. *(Documentation required: Confirmation letter from hospital staff.)*
	Institution in which the applicant has resided for more than 30 days (i.e. IMD's) with discharged pending within one week. Upon release, no subsequent residence having been identified and lacking the resources and support networks to obtain housing. *(Referral from clinician or letter from the institution on letterhead describing circumstances of residence, date(s) of entry and exit, conservator's name if applicable.)*

By signing below I am verifying that ____(name of applicant) meets the criteria for homelessness as indicated above, and resides in Contra Costa County.

Service Provider's Name:	Agency:
Provider's Signature:	Date:
Applicant's Signature:	Date:

Shelter Plus Care Housing Stabilization / Service Plan *Client's Name: ____________________*

Issue / Service Domain	Action Plan	Service Provider (if applicable)	Frequency of contact
Housing Search			
Case Management/ Service coordination			*(S+C requires at least monthly)*
Recovery Issues/ Relapse Prevention Planning			
Mental Health services			
Health Care			
Income / Financial management			
Life Skills / Supports (medications, personal care, home care, social support, etc.)			

Client Signature: ______________________________ *Date:* ______________________

Provider Name: ____________________ *Provider Signature:* ______________________