A Community of Friends (ACOF) Housing Intake Form

OFFICIAL USE	
Received by: _____	Response Date: _____
Date Received: _____	Date Updated: _____
Time Received: _____	W-L#_____ (YYYYMMDD##)

What property are you applying for? **Step Out Apartments**

Have you ever applied for housing at an ACOF building ? ❑ Yes ❑ No

Have you ever lived in an ACOF building? ❑ Yes ❑ No

If you answered "Yes" to any of the above questions, which property(ies)? _____

Applicant Name: _____

Mailing Address: _____

Phone Number: _____ Other Number: _____

Emergency Contact Name: _____ Phone Number: _____

Date of Birth	Last 4 digits of SS#	Source(s) of Income	Monthly Income	Full Time Student?
			$	❑ Yes ❑ No

Please complete questions A to D.

A. Do you have a diagnosed disability? ❑ Yes ❑ No

B. Where are you currently living? (*If applicable, please check the box that applies and list the name of the facility*.)

- ❑ Transitional Program _____
- ❑ Shelter _____
- ❑ Crisis Program _____
- ❑ Other: _____

C. How long have you been homeless? _____

D. Case Manager information (if any):

Service Provider/Case Manager: _____ Title: _____

Agency Name: _____ Address: _____

Phone Number: _____ Fax Number: _____ Email Address: _____

*__OPTIONAL__: *-I hereby authorize my case manager to receive information regarding my application and further authorize Property Management to exchange and release personal records regarding my application with/to my case manager.* _____ *(Applicant Initials)*

-I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief.
-I/we understand that false statements or information are punishable under federal law and are cause for denial of housing and will be grounds for immediate termination and cancellation of the rental agreement at the option of the landlord.

_____ _____

Applicant Signature **Date**

EQUAL HOUSING OPPORTUNITY

*Please mail or fax the completed form directly to:
Step Out Apartments, 2010 E. El Segundo Blvd., Compton, CA 90222
Fax (310) 637-0473
Unsigned forms will not be accepted.

Note: If applicant requires an interpreter or has a disability that requires special accommodations, please contact the Property Management Company so that reasonable accommodations can be made to meet applicants needs.

Updated: January 2013

Transitional Age Youth (TAY) Housing Application

Youth Development Services
3530 Wilshire Blvd.
Los Angeles, CA 90010
Tel: (213) 351-0100

☐ **THP** (*Ages 18-21)* ☐ **THP-Plus** *(Ages 18-24)*

General Information

(Please Print)

Name: _____ Application Date: _____ / _____ / _____

Primary Address: _____

City: _____ State: _____ Zip Code: _____ Gender: ☐ Male ☐ Female

Home Phone: ( ) _____-_____ Cell/Pager: ( ) _____-_____

Work Phone: ( ) _____-_____ ext._____ Date of Birth: _____/_____/_____ Age: ____

E-Mail: _____

Social Security Number: _____-_____-_____ Primary Language: _____

Did you age-out of foster care? ☐ Yes ☐ No Date you aged-out: _____/_____/_____

Living situation: ☐ Homeless ☐ Family ☐ Shelter ☐ Friends ☐ Other _____

Do you have a mentor or other significant adult relationship? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If yes, how many children do you have? _____

Do you have a California ID/Driver's License? ☐ Yes ☐ No ID/Driver's License No. _____

Parent/Guardian Information

Name: _____Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Referral/Agency Source

Name of person who referred you to transitional housing: _____

Relationship: _____ Agency: _____

Work Phone: ( ) _____-_____ E-Mail: _____

Rev: 02/2009

Education

Check Highest Grade Completed:

Elementary: ☐ 5 / ☐ 6 Junior High: ☐ 7 / ☐ 8 High School: ☐ 9 / ☐ 10/ ☐ 11/ ☐ 12

Last School Attended: _____

Do you have an Individual Education Plan? ☐ Yes ☐ No

Do you possess one of the following? ☐ High School Diploma ☐ GED ☐ Other _____

Date of High School Graduation: _____/_____/_____ Date Passed GED: _____/_____/_____

Last College/Trade School Attended: _____Units Completed: _____

Employment/Financial Information

Are you currently employed? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

How many hours per week do you work? _____

Name of Employer: _____

Address: _____ City: _____ Zip Code: _____

Supervisor: _____ Supervisor's Phone: ( ) _____-_____

Date Hired: _____/_____/_____ Hourly Salary $_____ Monthly Salary: $_____

Title and Description of Duties: _____

_____

_____

If not employed, what is your primary source of income?

☐ General Relief ☐ Social Security Insurance ☐ No Income

☐ Other (Explain): _____

Do you have a savings account? ☐ Yes ☐ No Balance: _____

Do you have a checking account? ☐ Yes ☐ No Balance: _____

Medical/Psychiatric/Substance Abuse History

Do you have Medi-Cal? ☐ Yes ☐ No Do you have private insurance? ☐ Yes ☐ No

Doctor's Name: _____ Phone No. ( ) _____/_____

Dentist's Name: _____ Phone No. ( ) _____/_____

Please list any medical conditions past or present: _____

_____

Please list any mental health issues past or present: _____

_____

Please list any prescribed medications that you are currently taking: _____

_____

Have you ever been hospitalized? If yes, please explain: _____

_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Do you currently use drugs? ☐ Yes ☐ No If yes, what types and how often do you use them? _____

_____

Do you smoke cigarettes? ☐ Yes ☐ No

Legal/Gang History

Are you or have you ever been on Probation/Parole? ☐ Yes ☐ No

If yes, please check the appropriate box: ☐ Juvenile ☐ Adult

Please provide the name and contact number of your Probation/Parole Officer: _____

_____

If you are on Probation/Parole, please explain the nature of the incident? _____

_____

Are you now or were you ever affiliated with a gang? ☐ Yes ☐ No

What gang? _____ Current status: _____

Life Skill Knowledge

Do you know how to cook? ☐ Yes ☐ No

Please give an example of a well-balanced meal you know how to cook? _____

_____

Do you know how to clean? ☐ Yes ☐ No

Please describe how would you clean a kitchen? _____

_____

Have you ever had a roommate? ☐ Yes ☐ No

If yes, was the experience positive or negative? (Explain): _____

_____

- Can you make a monthly budget? ☐ Yes ☐ No
- Do you pay bills on time? ☐ Yes ☐ No
- Do you own credit cards? ☐ Yes ☐ No
- Do you owe money on school loans? ☐ Yes ☐ No
- Do you know how to use public transportation? ☐ Yes ☐ No
- Do you have any pets? ☐ Yes ☐ No

Personal Goals

Please describe how getting into a transitional housing program will help meet your short and long term goals?

_____

_____

_____

_____

I hereby certify that the information I have completed is true and correct to the best of my knowledge,

_____ _____

Applicant's Signature **Date**

**The Transitional Age Youth Housing Application and supporting documentation/information is privileged and confidential. Distribution and/or reproduction of any record or information outside the intended and approved use is strictly prohibited. Illegal or misuse of this information is punishable by fine and/or imprisonment.

SOUTHERN CALIFORNIA HEALTH & REHABILITATION PROGRAMS
(SCHARP)

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

_____ _____ _____
Name of Client / Previous Names | Birth Date | MIS Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES:

Step Out Transitional Housing
Name of Agency

2010 E. El Segundo Blvd. Compton, CA, 90222
Street Address | City, State, Zip Code

TO DISCLOSE PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider / Plan / Other

_____ _____
Street Address | City, State, Zip Code

INFORMATION TO BE RELEASED:

✓ Assessment / Evaluation ___ Results of Psychological Tests ✓ Treatment
___ Laboratory Results ✓ Medication History / Current Medications ✓ Diagnosis
___ Entire Record (Justify) ___ Other (Specify):

PURPOSE OF DISCLOSURE: (Check applicable categories)

✓ Client's Request ___ Other (Specify):

Will the agency receive any benefits for the disclosure of this information? _Yes ✓ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This Authorization is valid until the following date_____/_____/_____
(Usually 90 days, but never exceeding 1 yr.)

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

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a 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.

Right to Revoke This Authorization – I understand that I have the right to revoke this Authorization at any time by telling SCHARP in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to:

_____ _____
Contact Person Agency Name

_____ _____
Street Address City, State, Zip Code

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

Conditions – I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, SCHARP, 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 / Personal Representative **Date**

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

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

_____

DATE: _____/_____/_____
Month Day Year

04/2008

SOUTHERN CALIFORNIA HEALTH & REHABILITATION PROGRAMS
(SCHARP)

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

_____ _____ _____
Name of Client / Previous Names | Birth Date | MIS Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES:

_____
Name of Agency

_____ _____
Street Address | City, State, Zip Code

TO DISCLOSE PROTECTED HEALTH INFORMATION TO:

___Step Out Transitional Housing_____
Name of Health Care Provider / Plan / Other

2010 E. El Segundo Blvd. _____ _____Compton, CA, 90222_____
Street Address | City, State, Zip Code

INFORMATION TO BE RELEASED:

✓ Assessment / Evaluation ✓ Results of Psychological Tests ✓ Treatment
___ Laboratory Results ✓ Medication History / Current Medications ✓ Diagnosis
___ Entire Record (Justify) ___ Other (Specify):

PURPOSE OF DISCLOSURE: (Check applicable categories)

✓ Client's Request ___ Other (Specify):

Will the agency receive any benefits for the disclosure of this information? __ Yes ✓ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This Authorization is valid until the following date: _____/_____/_____
(Usually 90 days, but never exceeding 1 yr.)

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Right to Revoke This Authorization – I understand that I have the right to revoke this Authorization at any time by telling SCHARP in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to:

__Step Out (Appropiate Staff)__ _____SCHARP_____
Contact Person Agency Name

__2010 E. El Segundo_____ _____Compton CA, 90222_____
Street Address City, State, Zip Code

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

Conditions – I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, SCHARP, 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.

_X_____ _____
Signature of Client / Personal Representative **Date**

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

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

DATE: _____/_____/_____
Month Day Year

CERTIFICATION OF DISABILITY

DATE: _____

Dear Physician / Qualified Health Personnel:

_____ has claimed eligibility for a federally funded housing program due to a disability. The claim must be certified by a licensed physician or qualified health professional. For the purpose of this program, a disabled person is one who is seriously mentally ill; or has chronic problems with alcohol, drugs, or both; or has AIDS and related diseases. This disability must be expected to be of a long-continued and indefinite duration; substantially impede his/her ability to live independently, and is of such a nature that the disability could improve under more suitable housing conditions. Please provide the information requested below.

By: _____
Housing Authority Employee

I authorize the release of the information requested below:

_____
Signature of Applicant

MEDICAL CERTIFICATION

In my opinion, as a licensed physician /qualified health professional trained to evaluate such conditions _____ **does not** have a disability as defined above.
Applicant's Name

In my opinion, as a licensed physician /qualified health professional trained to evaluate such conditions _____ **does have** a disability as defined above.
Applicant's Name

Specifically this disability is as follows:

_____
_____
_____

Additional information concerning this disability:
This disability:

Is expected to be of a long-continued and indefinite duration
If YES, for how long _____ ☐Yes ☐No

Substantially impedes his/her ability to live independently ☐Yes ☐No

Is of such a nature that it could improve under more suitable housing conditions ☐Yes ☐No

Additional information concerning this disability:

This disability is: ☐Serious Mental Illness
☐AIDS/Related Disease
☐ Chronic Substance Abuse
☐Multiple Diagnosis (specify) _____
☐ Other (specify) _____

Signature: _____ **Print Name:** _____

Professional Title: _____ **Telephone:** _____

License Number: _____

Name of Medical Group (stamp preferred): _____

Organization Stamp:

Address: _____ Date: _____

DATE:____/____/____ ❑ EMERGENCY SHELTER ❑ TRANSITIONAL HOUSING

2015 INDEPENDENT LIVING PROGRAM INTAKE FORM

Agency Name: Site Address:

(1) YOUTH NAME: _____ _____ (2) ID #: _____
LAST FIRST

(3) Date of Birth: __/__/____ (4) Age: ____ (5) SS#: __ __ __ - __ __ - __ __ __ __ (6) Gender (circle): Male Female Transgender

(7) Spouse's Name: _____ (8) # of children w/ youth: _____ (9) Emergency Contact/Phone #: _____

(10) YOUTH IS: ☐ Between 18 and 21years old, AND one of the following:
- ☐ a former LA County foster youth who was in foster care after the age of 16
- ☐ a former foster youth who resides with a related legal guardian [i.e. Kin-Guardian Assistance Payment (GAP) youth] (NOTE: All youth age 14 to 21 are eligible in this category regardless of age when court jurisdiction was terminated)
- ☐ a former foster youth adopted after his/her 16th birthday(and finalized adoption after Jan.1, 2000)
- ☐ ran away from suitable placement and turned himself/herself in

	11. RACE (choose one):
	American Indian or Alaskan Native
	Asian
	Black or African American
	Native Hawaiian / Other Pacific Islander
	White
	American Indian or Alaskan Native AND White
	Asian AND White
	Black or African American AND White
	American Indian or Alaskan Native AND Black or African American
	Other / Balance

	12. ETHNICITY (choose one)
	Hispanic or Latino
	Non-Hispanic or Non-Latino

13. CURRENTLY HOME ON PROBATION? ☐ YES ☐ NO

14. CURRENTLY RECEIVING MEDI-CAL? ☐ YES ☐ NO

	15. WHICH DEPARTMENT REFERRED YOUTH TO PROGRAM?		
	DCFS		Neither
	Probation		

	16. WHAT SPECIAL NEEDS DOES CLIENT HAVE? (check all that apply)
	Mentally Ill
	Substance Addiction
	HIV/AIDS
	Domestic Violence
	Developmentally Disabled
	Physically Disabled
	Teen Mother

	17. HOUSEHOLD COMPOSITION
	Unaccompanied Male
	Unaccompanied Female
	Single Parent Family (male-headed)
	Single Parent Family (female-headed)
	Two Parent Family
	Couple (no children)

18. IS YOUTH HOMELESS? ☐ YES (answer 19 and 20 below) ☐ NO

	19. IF HOMELESS, ASK PRIOR LIVING SITUATION
	Foster Care
	Streets
	Camp Community Placement
	Emergency shelter
	Transitional housing
	Jail/Prison
	Psychiatric facility
	Hospital
	Substance Abuse treatment facility
	Domestic violence shelter
	Rental housing
	Staying with family/friends
	Not Available
	Other: _____

	20. IF HOMELESS, ASK CIRCUMSTANCES CAUSING HOMELESSNESS				
	Emancipation		Release from jail/prison		Family/friends asked client to leave
	GR Cuts		Release from hospital		Moved
	Change in Income		Illness		Drugs/Alcohol
	Lost Job/Layoff		Health Problems		Not Available
	Eviction		Domestic Violence		Other (specify):

(21) YOUTH STATEMENT: I understand that I am supplying information to _____ and the Los Angeles Homeless Services Authority (LAHSA) voluntarily in order to receive services that I need and for which I may be eligible. I also understand that LAHSA may give some of this information to other government agencies and/or service providers so that these agencies may better assist me and that LAHSA may use this information in order to document the problems and needs of homeless people. I hereby certify that, to the best of my knowledge, the above information is true and correct.

(22) YOUTH SIGNATURE: _____ DATE: _____

(23) IMPORTANT DATES: Date Referred: _____ Date Screened: _____
Date Accepted into Program: _____ Date Moved In: _____

(24) REFERRING DEPARTMENT INFO:

DCFS CSW: _____ CSW Phone #: _____ SCSW: _____ SCSW Phone #: _____

Probation DPO: _____ DPO Phone #: _____ SDPO: _____ SDPO Phone # _____

PDJ#: _____ (25) INTAKE WORKER SIGNATURE: _____ DATE: _____

ILP Verification of Emancipation Status/Consent For Release of Information

LA County Department of Children & Family Services/ Department of Probation

CLIENT'S INFORMATION (Please Print- to be filled out by client only)

Name: _____ Date of Birth: _____ Age: _____

Phone Number: _____ Social Security Number: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

I, _____ hereby authorize the Los Angeles County Department of Children and Family Services (DCFS) and/or Department of Probation (Probation) to release my foster care status and case information to the agency listed below. I also authorize the agency listed below to release my case information to DCFS and/or Probation. This information is to be used solely for the purpose of securing emergency, transitional or permanent housing, statistical purposes, ensuring delivery of service, and program goal compliance.

Client's Signature: _____ Date: _____

HOUSING AGENCY INFORMATION (Please Print)

Agency Name: SCHARP- Step Out Email: Alma.Ocampo@scharpca.org

Agency Address: 2010 E. El Segundo Blvd. Compton CA 90220

Phone Number: (310) 637-0917 Fax Number: (310) 637-0473

Employee Name: Alma D. Ocampo Employee Title: Administrator Assistant

I, Alma D. Ocampo , an employee of SCHARP- Step Out , hereby agree to solely utilize the information obtained from the Los Angeles County Department of Children and Family Services (DCFS), Youth Development Services Staff and/or Department of Probation for the purpose of assisting the aforementioned youth/client in securing emergency, transitional or permanent housing and for agency program monitoring, statistics, and delivery of service compliance.

Employee's Signature: Date:

HOUSING AGENCY TO FAX COMPLETED FORM:

***For DCFS Youth**: to Greg Breuer at (213) 637-0035 and call (213) 351-0187 to Verify Receipt*

***Probation Youth**: to John Thompson at (213) 637-0036 and call (213) 351-0156 to Verify Receipt*

TO BE COMPLETED BY LA COUNTY DCFS YDSD OR DEPT. OF PROBATION STAFF ONLY

☐ **ILP THP Housing (For youth between the ages of 18 and 21)** **(Check All That Apply)**

☐ **ILP/ HSP Housing (For youth between the ages of 18 and 22)**

The above mentioned client is/was a current or former foster youth from either the L.A. County Department of Children and Family Services or the Department of Probation. Yes: _____ No: _____

☐ **THP+ Housing (For youth between the ages of 18 and 24)**

The above mentioned client *aged-out* of foster care from either the Los Angeles County Department of Children and Family Services or the Department of Probation. Yes: _____ No: _____

Youth is eligible for _____ months in the THP-Plus program.

Previous THP+ Start Date: _____

The client's court case is closed. Yes: _____ No: _____ Projected Term Date if known: _____

Case Termination Date: _____ ILP Eligible: Yes: _____ No: _____

_____

DCFS/PROBATION STAFF NAME

_____ _____ _____

DCFS/PROBATION STAFF SIGNATURE Title Date

If you have questions, please call John - 213/351-0156 or Greg - 213/351-0187

ILP Eligibility criteria can be found on www.ILPOnline.org ***Rev. 04/2015***

After leaving/emancipating from _____. I _____will not have anywhere to reside, therefore I will be homeless. client name

X _____ _____

Signature Date