**BEHAVIORAL HEALTH ADMINISTRATION**

# Homeless I.D. Project FY 2023 APPLICATION/ INTAKE

Client Name: _____ D.O.B.* _____ Phone number: _____

*If Client is under age 18, is he/she under the care of an adult that is homeless/imminent risk of homelessness AND has a mental illness or co-occurring substance use disorder: ___Yes ___No

Does the Client have needed documentation to obtain Identification Card/Birth Certificate? __Yes __No

If Yes please list: _____

Client MA #, Gray Zone # or Medicare #: _____ Social Security # _____

Current Living Situation: __ Emergency Shelter __Transitional Housing __Hospital __ Hotel/Motel

__ Jail ___Street, Park, Car, Bus Station, Bridge, etc. ___Living with Relatives/Friends

Other: _____ Zip Code of Last residence: _____

Chronically Homeless (homelessness for a year or longer, or at least four episodes of homelessness in the last three years): ___Yes ___No

Housing Status: ___Literally Homeless ___Imminently Losing Housing

Veteran: ___Yes __No Gender: __ Male __ Female Race: _____ Ethnicity: _____

Disability: Mental Illness _____ Co-occurring _____

Person completing form: _____ Phone # _____

Agency & Address: _____

Documentation of Homelessness Received: ____ Yes ____ No *CSA will maintain file applications

**Request**: (Please check all that apply)

____ State Identification Card ***OR*** ____ Drivers License Renewal

____ Birth Certificate Which state: _____

*Please note that follow up is needed to verify that documents (ID/BC) were obtained by client within 45 days

**Follow Up Date (45 days from Application):** _____

FOR CSA OFFICE USE ONLY: **CSA Making the Request**: _____

Requesting CSA has verified that this is not a duplicate request for funding for this individual within the past 6 months: ___Yes ___No *Note: There is a **maximum of 2** IDs or Birth Certificates

| FOR ID: | For Birth Certificate: |
|---|---|
| Check payee: _____ | Check payee: _____ |
| AMOUNT: _____ | AMOUNT: _____ |
| Phone #: _____ | Phone #: _____ |
| Payee address: _____ | Payee address: _____ |
| **Tax ID #:** _____ | **Tax ID #:** _____ |
| Account # if applicable: _____ | Account # if applicable: _____ |

Total Amount Approved by CSA: _____ Amount Denied by CSA _____ Follow Up by CSA _____

_____ _____
Approved CSA Director or Designee Date

_____ _____ _____
CSA Fiscal Officer Date Approved YTD

Revised 7/28/2016 JB/KD

Date ID paid: _____

Date Birth Certificate Paid: _____

## Homeless Identification and Birth Certificate Project
## Instructions to make a referral

**PURPOSE:** Program provides funding for birth certificates and/or State Identification/Drivers License renewals.

**ELIGIBILITY:** To qualify, the individual must be experiencing homelessness or is at imminent risk of becoming homeless, and have a mental illness or co-occurring substance use disorder.

Minor children in the care of a qualifying adult that meets the homeless and disability criteria are also eligible for birth certificates.

**INSTRUCTIONS TO MAKE A REFERRAL:**

1. Verify individual meets the following requirements:

    a. Is age 18 or older ***OR*** If the individual is under age 18, they must be in the care of an adult that meets criteria below
    b. Has a mental illness or co-occurring substance use disorder
    c. Currently homeless or at imminent risk of becoming homeless
    d. The individual may not have requested funds from this project within the past 5 months
    e. Individual is eligible for services within the public mental health system

2. Complete the application packet with the individual. Application includes the following:

    a. The "***Behavioral Health Administration Homeless I.D. Project FY 2024 Application/Intake***".

    b. The ***"Maryland Homeless I.D. Project Documentation of Homelessness***". This is a self-verification of homelessness completed by the individual (including current situation, how long they have experienced homelessness, how many episodes of homelessness, what makes them at risk of homelessness, etc.). ****If the individual is currently staying in a shelter, please include a letter from the shelter.***

3. Submit the application packet either by fax or mail. ***(NOTE: Application packets should be sent to the Core Service Agency where the individual is residing/ located)***

| | |
|---|---|
| Offices: | Mid Shore Behavioral Health, Inc. |
| Fax: | 410-770-4809 |
| Mailing Address: | 28578 Mary's Ct, Suite 1<br>Easton, MD 21601 |
| Telephone: | 410-770-4801 |
| Contact: | Yvette Hynson |

***If you have questions please call***
***Mid Shore Behavioral Health, Inc. at 410-770-4801***

# MARYLAND HOMELESS I.D. PROJECT

## of Homelessness

**Please use the following space to describe the applicant's current living situation. If the applicant is currently in the detention center, please describe their living situation prior to incarceration. <u>If the applicant is currently residing in a shelter, transitional housing program, or other temporary housing facility additional documentation of homelessness, i.e. letter on agency letterhead must be included with this form.</u>**

## Self-Verification (Brief statement from client saying he/she is homeless or at-risk of losing his/her housing):

_____

_____

_____

_____

_____

_____

_____

## <u>(Please ask the Applicant these questions):</u>

1. Where do you typically stay at night? _____

2. Do you know the name of the shelter or housing program where you stay?

_____

3. Do you work with any of the outreach teams or case management programs? ____ Yes ____ No

If yes, do you know the name of the agency or the worker you see? _____

_____

**I certify that the information provided regarding my homeless status is accurate and true.**

**Date:** _____ **Signed:** _____ (Applicant)

**Date:** _____ **Witness:** _____