St. Clair County Community Mental Health
3111 Electric Ave.
Port Huron, Michigan 48060

Housing Assistance Fund Intake

Date of Request: _____

1. CMH Board: St. Clair County CMH

2. Individual: _____ Case #: _____

3. Date of Birth: _____ 4. Sex: ☐Female ☐Male

5. Race: African American☐ Caucasian☐ Hispanic American☐
   Native American ☐ Other (specify)☐ _____

6. Status of Individual in relation to housing need:

7. Individual _____ w/children # _____
   Couple _____ w/children # _____

8. Current Living Arrangement: (indicate one/all that applies

- ☐ On the street
- ☐ Shelter
- ☐ Restrictive Setting (Group Home, AFC, etc.)
- ☐ Institution or Nursing Facility
- ☐ Other (specify): _____

8. Does the individual meet the definition of literally homelessness as defined in the HUD Standards (III A in policy 07-003-0010)? **Yes** ☐ **No** ☐

   Is the individual "at risk" of homelessness? **Yes** ☐ **No** ☐

   If yes, please describe: _____

   Court Eviction Notice? **Yes** ☐ **No** ☐
   (If the individual has an eviction notice, please attach)

9. Complicating Medical Condition: **Yes** ☐ **No** ☐

   If yes, please describe: _____

10. Does this individual have a diagnosis of substance abuse? **Yes** ☐ **No** ☐ **Unknown** ☐

11. Has this individual been hospitalized for a psychiatric disability in the last 12 months?

Yes ☐ **No** ☐ **Unknown** ☐

12. How many times has this individual moved in the past twelve months (with each hospitalization counting as one move)? _____

13. Primary diagnosis (code from DSM - 5): _____

14. Secondary diagnosis (code from DSM - 5): _____

15. Briefly describe the purpose of this request: _____

16. Is this request being made to:

☐Maintain current living arrangement (to address eminent risk of homelessness)

☐Obtain a living arrangement (moving from literally homeless, transitioning from restrictive setting)

17. Have you made a referral to DHHS Emergency Relief for assistance? **Yes**☐ **No**☐
(Please attach a copy of denial)

What other sources of assistance have you sought? _____

18. Has the individual gone to HARA? **Yes**☐ **No**☐ **Date Went:** _____

19. What internal (CMH) resources have you pursued for this individual (referral to IPS, etc.)?

20. Does this individual have income (including SSI,employment)? **Yes**☐ **No**☐

Please Explain: _____

21. If no income, what efforts are being made to secure income? _____

22. How much of their individual's own resources are being used toward their housing needs? _____

23. What is the long term housing plan for this individual? (Check all that apply)

a. Apartment☐ b. Own Home☐ c. Desires Roommate☐

d. Adult foster care☐

24. Is there a goal/objective in the IPOS? **Yes**☐ **No**☐

25. How will the individual pay for their housing in the future? _____

26. Is the individual a participant in SCCCMH Services? **Yes**☐ **No**☐ **In Process**☐

27. Is the individual actually engaged in services/treatment and keeping appointments? **Yes**☐ **No**☐
(Print out appointment schedule for last 3 months)

	Budget		**Payment**
	CMH/Other		CMHSP
Item	**Requested**	**Approved**	**Actual Expenditures**
Rent (B3)	_____	_____	_____
Security/Damage Deposit (B3/-GF)	_____	_____	_____
Utility (Security Deposit/Reconnection)	_____	_____	_____
Furnishing (B3/-GF)	_____	_____	_____
Emergency Shelter (B3)	_____	_____	_____
Total	_____	_____	_____

_____ _____
Preparer Signature Date

Submit to Supervisor

_____ _____ **Approved**☐ **Denied**☐
Supervisor Signature Date

_____ _____ **Approved**☐ **Denied**☐
Chief Clinical Officer Signature Date