

Request # \_\_\_\_\_

**BEHAVIORAL HEALTH ADMINISTRATION**  
**Homeless I.D. Project SFY 2023 APPLICATION/ INTAKE**

Client Information:

Client Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone number: \_\_\_\_\_

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:  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 # \_\_\_\_\_

Address: \_\_\_\_\_

Check made payable to: \_\_\_\_\_

Documentation of Homelessness Received:  Yes  No

\*CSA will maintain file applications

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

State Identification Card (\$24.00 Maximum)

Birth Certificate (Please indicate if Birth Certificate is from a state other than Maryland) (\$50.00 Maximum)

**FOR 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

Check payee: \_\_\_\_\_ Phone #: \_\_\_\_\_

Payee address: \_\_\_\_\_

**Tax ID #:** \_\_\_\_\_ **Account # if applicable:** \_\_\_\_\_

Total Cost: \_\_\_\_\_ Amount Requested: \_\_\_\_\_ Amount Approved by CSA: \_\_\_\_\_

(For CSA use Only)

\_\_\_\_\_  
Approved CSA Director or Designee Date

\_\_\_\_\_  
CSA Fiscal Officer Date

Approved YTD \_\_\_\_\_