Request #_____

BEHAVIORAL HEALTH ADMINISTRATION

Homeless I.D. Project SFY 2024 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 _____