

Request # _____

BEHAVIORAL HEALTH ADMINISTRATION
Homeless I.D. Project SFY 2025 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 _____