

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
SUBSTANCE ABUSE PREVENTION AND CONTROL BUREAU  
HOMEKEY+ REFERRAL FORM**

*The information provided below will be used to determine program eligibility and the most appropriate Homekey+ site.*

REFERRING ENTITY INFORMATION	
Date of Referral: _____	Name of Provider Organization: _____
Referring Staff Name: _____	Referring Staff Title: _____
Referring Staff Phone Number: _____	Referring Staff Email Address: _____
Alternate Contact Name: _____	Alternate Contact Title: _____
Alternate Contact Phone Number: _____	Alternate Contact Email Address: _____

CLIENT INFORMATION	
Client Name (First, Middle, Last): _____	DOB: _____
Email: _____	Phone Number: _____
SAGE PCNX#: _____	HMIS#: _____
VI-SPDAT Score: _____	or LA-HAT Score: _____
Current living situation? <input type="checkbox"/> RBH <input type="checkbox"/> RH <input type="checkbox"/> Other: _____	
Is the client "document ready": * <input type="checkbox"/> Yes <input type="checkbox"/> No	
<small>* To be considered "document ready," the client would need the following documents (Physical copy &amp; HMIS upload): Government issued ID (California ID, Driver's License, Passport, or Military ID), Income verification (pay stubs, bank statements, or proof of benefits), and homeless verification.</small>	

**GENERAL ELIGIBILITY**

1. Is the client experiencing homelessness, as defined under 24 CFR Part 578.3: Literally homeless, At-risk of homelessness, Fleeing/Attempting to flee DV, or Homeless under other federal statutes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the client have an annual income at or below 30 percent of Area Median Income (AMI)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the client received SUD services within the SAPC network in the last 9 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is the client working with a SAPC Housing Navigator?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Is the client in need of Supportive Services (SS)?** (Not a mandate for Homekey+)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If question #5 was answered as "yes" (\*\*), please specify what types of SS supports and services the client needs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CLIENT DEMOGRAPHICS**

Is the client of Mexican/Hispanic/Latino descent?  Yes  No

RACE/ETHNICITY: (Select all that apply)			
<input type="checkbox"/> American Indian/Alaskan Native/Indigenous	<input type="checkbox"/> Hispanic/Latin(a)(o)(x)	<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> White
<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> Client Prefers Not to Answer	<input type="checkbox"/> Client Doesn't Know		
GENDER:			
<input type="checkbox"/> Man	<input type="checkbox"/> Woman	<input type="checkbox"/> Nonbinary	
<input type="checkbox"/> Transgender	<input type="checkbox"/> Culturally Specific Identity (e.g. TwoSpirit)	<input type="checkbox"/> Different Identity	
<input type="checkbox"/> Questioning	<input type="checkbox"/> Client Prefers Not to Answer	<input type="checkbox"/> Client Does Not Know	
SEXUAL ORIENTATION:			
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian	<input type="checkbox"/> Bisexual
<input type="checkbox"/> Client Prefers Not to Answer	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Other	

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<b>SPECIAL POPULATIONS:</b>			
<b>Veteran Status:</b> Is the client a veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Older Adults:</b> Is the client aged 55 or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>LGBTQ+:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>HIV/AIDS:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Legal:</b> Is the client a justice-involved participant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>IV Drug Use:</b> Does the client have a history of IV drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>AB109:</b> Is this an AB109 client? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure/Client Doesn't Know			
<b>TRANSITION-AGED YOUTH (TAY):</b> Is the client between the ages of 18 and 25? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify below:			
<input type="checkbox"/> Current Foster Youth	<input type="checkbox"/> Former Foster Youth	<input type="checkbox"/> Never in Foster Care	

  

<b>CURRENT LOCATION:</b>			
<input type="checkbox"/> SPA 1 - Antelope Valley	<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> SPA 5 - West LA	<input type="checkbox"/> SPA 7 - Southeast LA
<input type="checkbox"/> SPA 2 - San Fernando Valley	<input type="checkbox"/> SPA 4 - Metro LA	<input type="checkbox"/> SPA 6 - South LA	<input type="checkbox"/> SPA 8 - South Bay/Long Beach

<b>EMPLOYMENT/EDUCATION/INCOME INFORMATION</b>			
1. Is the client currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Contract <input type="checkbox"/> Seasonal/Sporadic		
2. Is the client currently attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
3. <b>Does the client receive any non-cash benefits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer			
Select all that apply	<input type="checkbox"/> Food Stamps/CalFresh (SNAP) <input type="checkbox"/> WIC <input type="checkbox"/> CalWORKs <input type="checkbox"/> Other source (Specify): _____		
4. <b>Does the client receive cash income? (Required)</b> <input type="checkbox"/> Yes*** <input type="checkbox"/> No			
<i>If question #4 was answered as "Yes" (***) , then the following questions are <b>required</b>. Income verification to occur during the leasing process. If answered as "No", proceed to question #5.</i>			
<b>Income Source and Monthly Income:</b>			
<input type="checkbox"/> Earned Income (Employment wages/Cash)	\$	<input type="checkbox"/> Temporary Assistance for Needy Families (TANF) (CalWORKs)	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> General Relief (GR)	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> Retirement Income from Social Security	\$
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	\$	<input type="checkbox"/> Pension or Retirement income from a former job	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$	<input type="checkbox"/> Child Support	\$
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$	<input type="checkbox"/> Alimony and other spousal support	\$
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/> CalWORKs	\$
<input type="checkbox"/> Worker's Compensation	\$	<input type="checkbox"/> Other Source (Specify):	\$
<b>Total Monthly Cash Income for Individual</b>	\$		
<b>Total Annual Income for Individual:</b>	\$		

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**TREATMENT & SERVICES**

1. Does the client currently receive SUD treatment services?  Yes  No If yes, specify provider: \_\_\_\_\_
2. Does the client request a referral for an alternate SUD provider if housing is located outside of current SPA?  Yes  No
3. Does the client consent to Supportive Services?  Yes  No
4. Select all that apply to the client:  Physical Health  Mental Health  Cognitive Impairments  N/A

**HOUSING PREFERENCES**

1. Is there any SPA(s) where the client would prefer to live in? (Select all that apply)

<input type="checkbox"/> SPA 1 - Antelope Valley	<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> SPA 5 – West LA	<input type="checkbox"/> SPA 7- Southeast LA
<input type="checkbox"/> SPA 2 – San Fernando Valley	<input type="checkbox"/> SPA 4 – Metro LA	<input type="checkbox"/> SPA 6 – South LA	<input type="checkbox"/> SPA 8 - South Bay/Long Beach

2. Is there any SPA(s) where the client CANNOT live in? (Select all that apply)

<input type="checkbox"/> SPA 1 - Antelope Valley	<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> SPA 5 – West LA	<input type="checkbox"/> SPA 7- Southeast LA
<input type="checkbox"/> SPA 2 – San Fernando Valley	<input type="checkbox"/> SPA 4 – Metro LA	<input type="checkbox"/> SPA 6 – South LA	<input type="checkbox"/> SPA 8 - South Bay/Long Beach

If any selected for question #2, specify reason: \_\_\_\_\_

3. Does the client want or need to be housed with any of the following special population groups:

Transition-Aged Youth (age 18-25)  Older Adults (age 55 and over)

4. Is the client requesting a fully accessible unit?  Yes  No

5. If “yes” selected for question #5, select all that apply. If “no,” skip question #6.

<input type="checkbox"/> Cannot climb stairs	<input type="checkbox"/> Independently uses walker/cane/crutches
<input type="checkbox"/> Independently uses a motorized wheelchair	<input type="checkbox"/> Independently uses a manual wheelchair
<input type="checkbox"/> Significant visual impairment	<input type="checkbox"/> Significant hearing impairment
<input type="checkbox"/> Other additional information, specify:	

6. Does the client/household have a service animal(s) or pet(s) that will accompany them into housing?

Yes  No If yes, # of animals: \_\_\_\_\_ Type: \_\_\_\_\_

**HOUSEHOLD INFORMATION**

*(Complete if the client is pregnant or requesting to be housed with children)*

1. Is the client pregnant?  Yes  No  Client Doesn't Know If yes, how many weeks? \_\_\_\_\_
2. Is the client requesting to be housed with a partner or adult dependent?  Yes  No
- a. Annual income of this person: \$ \_\_\_\_\_  
*(Eligibility subject to total household income and AMI%)*
3. Is the client requesting to be housed with a minor child(ren)?  Yes  No

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a. If applicable, please list the information of the minor child(ren) below:

Name	DOB	Age	Gender	Legal Custody
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

**HISTORY OF HOMELESSNESS**

Is the SAPC Homeless Verification Form attached to this referral? **(Required)**  Yes  No

Submit all Homekey+ referral applications to SAPC’s Homeless Services Unit at [DPH-SAPC\\_HSU@ph.lacounty.gov](mailto:DPH-SAPC_HSU@ph.lacounty.gov).

**SAPC SOC USE ONLY**

1. SUD treatment and eligibility confirmed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Homeless eligibility confirmed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. AMI at or below 30%:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Date Referral Submitted:	