San Mateo County Mental Health Services
225 – 37th Avenue, Room 320 San Mateo, CA 94403

Mental Health Association
Phone: 650.368.3345 Ext. 133 FAX: 650.368.9017

Date		

HOUSING ASSISTANCE FUND REQUEST AUTHORIZATION

Client Name	
Address	
Request Made By (Name, Title, Agency or relationship to client)	
Phone Number	
Request Made For	☐ Older Adult ☐ Adult ☐ Transition Age Youth

Instructions for Payment

Maximum Amount Requested	$				
These funds will be paid out in the following manner	☐ One time only	☐ Monthly	☐ Other		
Signature Authorization					
Request Approved	☐ Yes	☐ No			
Under $200 may be approved by the Unit Chief Over $200 must be approved by Adult Deputy/Manager					
Signature		Date			

Agency Request ☐	Address of apartment	

Client ☐ is ☐ will be on housing supplement program		
☐ Section 8	☐ Shelter + Care ☐ Tenant based ☐ Sponsor based	☐ Aftercare ☐ Client receives vouchers ☐ Certificates
☐ Client is not on a housing supplement program		

Specific Request

1. Vacancies			
☐ Roommate Absence	☐ Hospitalization	☐ Moved without notice/disappearance	☐ Refusal to pay or leave an apartment
	☐ Death	☐ Other	
☐ Moved with notice, inability to fill vacancy	Explain		

Indicate Time Frame of Vacancy	Start Date				End Date			

2. Move In Costs		
☐ Deposit/First & Last Month's Rent	☐ Partial Payback	☐ Full Payback
Explain situation and how much will be repaid		
☐ All other resources investigated		
Explain		

3. Damage to Apartment	
☐ Not a result of client's behavior	
Explain why unable to negotiate with Housing Authority or owner	
☐ Result of client's behavior	
Explain	
☐ Clinical follow-up plan (please attach)	☐ Payback plan (mandatory)

4. Maintenance
☐ Yearly Inspection
Explain maintenance problem:
☐ Necessary for change of tenancy

5. Rent
☐ Rent Increase/Rent exceeds maximum certificate (S+C Sponsor Based)
Explain:
☐ Rent increase that client can't afford. (Attach an explanation and include a plan to relocate)

6. Hold Apartment
Explain:

7. Residential Treatment	
☐ Cordilleras Suites	☐ Wally's Place
☐ Eucalyptus	☐ Hawthorne
☐ G & A Rate	☐ B & C Rate

8. Loss of Income
☐ Illness/Inability to work (mandatory payback)
☐ New Entitlement Pending
☐ Disruption of Entitlement
Explain:

9. Other	
Describe situation:	
☐ Payback	☐ No Payback
Reason:	

10. Plan
☐ Clinical follow-up plan (please attach)

Disbursement Instructions		
☐ Pay Now	☐ Pay upon invoices	
If payment is to be made upon invoice, when will they arrive and how many are expected?		
Check to be paid payable to:		
Address		
City/State/Zip		
Direct Questions to		
	Phone	Fax

Payback
I, , agree to pay back $
of the money provided from the Mental Health Wrap Around Fund.
Payments should be made to: Mental Health Association of San Mateo County Wrap Around Fund 2686 Spring Street Redwood City, CA 94063
I have read, understand, and agree to pay back the funds in the amount above.

Client Signature		Date	
Conservator Signature		Date	
Representative Payee's Signature		Date	

San Mateo County Hold Harmless Agreement

As part of my rehabilitation resource plan, I accept the provision of goods and services under the Mental Health Division's Adult Wrap Around Fund.

The Wrap Around Fund provides for activities to enhance my ability to live in the least restricted setting.

I fully and completely release and hold harmless the County of San Mateo and its employees for any damages and/or injury whatsoever, including to the full extent allowed by law, liability which may result from my participation in this service or activity.
This agreement commences on the date of my signature below, and will be in effect for one year.

Client Signature		Date	
Conservator Signature		Date	
Witness (Provider)		Date	

Return completed and approved forms by mail to MHA, 2686 Spring Street, Redwood City, CA 94063 or fax to 650.368.2534.

Copy to chart
Copy to client
Copy to Adult Manager