



# Laverne Adolfo Transitional Housing Program for Former Foster Youth

## To the Referring Agency

- The person or agency obtaining an application for the Adolfo Housing Services is responsible for completing and submitting the referral documents.
- Having known the applicant for a reasonable period of time will help to ensure that you are able to complete the referral section of the application.
- If you need more information to make an accurate referral, please contact a person or agency recently involved with the applicant (example: ILP Worker, Group Home Supervisor, etc).
- The goal is to ensure the applicant is participating in the appropriate housing service. Before submitting the application, meet with the applicant to determine required eligibility criteria has been met.

## Program Criteria

- Have been in out-of-home care that was not privately funded (i.e. CPS, Probation, 26.5)
- Be legally emancipated and no older than 23 years
- Be responsible for developing an individualized service plan and purposefully work toward meeting established goals
- Be willing to abide by the agency's policies and procedures.

Applications for The Laverne Adolfo Transitional Housing program will be accepted up to 6 months prior to emancipation or up to the former foster youth's 23rd birthday.

## Types of Housing

**Laverne Adolfo Transitional Housing** and services are offered for participants for up to 24 months. Homeless certification is required for some housing placements.

**Permanent Supportive Housing for Persons with Disabilities** provides subsidized housing and services to former foster youth who are homeless or transitioning out of foster care, and have a verifiable disability that impede their ability to live independently. Homeless and disability documentation must be provided.

# Laverne Adolfo Transitional Housing Program for Former Foster Youth Application

*Submit the application and referral to:*

Sacramento County Department of Health & Human Services

Attention: Laverne Adolfo Transitional Housing Program / Laurie Hinshaw

925 Del Paso Blvd., Suite 500 Sacramento, CA 95815

(916) 879-1784 Adolfo Information Line

FAX: (916) 874-9280

## **Identification and Contact Information**

Name: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Your telephone number: (        ) \_\_\_\_\_

Alternative telephone number: (        ) \_\_\_\_\_

Name and phone number where we may leave a message if you cannot be reached:

\_\_\_\_\_ (        ) \_\_\_\_\_

Youth is currently homeless:

Are you married?         YES         NO

Do you have children:     YES         NO        If yes, how many \_\_\_\_\_

Do your children live with you?         YES         NO

The following documents are required with a fully completed application:

Birth Certificate     Social Security Card     DOJ Criminal Background Printout

Drivers License    or     California Identification Card     Medi-Cal Card

If youth is disabled or cannot show proof of citizenship:

Disability Verification     Verification of Legal Residency



## Authorization to Release Health Records

Adolfo Housing Program for Former Foster Youth Application

### Instructions:

**VERIFICATION:** We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See HIPAA Privacy policy and procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

**VERIFICATION for Personal Representative:** If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

**ABOUT THE FORM:** This authorization is a **Voluntary Form**. Be sure the individual understands it before signing.

**EXPIRATION DATE:** The expiration date cannot exceed one year from the client's signature date. In addition, if this release is for an event – enter the event expiration date.

**RIGHT TO REVOKE:** The individual has a right to revoke this form. When an individual revokes written authorization to disclose information, the County of Sacramento must boldly mark the authorization form "revoked" and include the date and signature of the requesting individual.

**COPY TO THE INDIVIDUAL:** If a Department within County of Sacramento initiates this authorization from an individual, the Department must provide the individual with a copy of the signed authorization.

### **VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:**

- The expiration date has passed or the onetime event is known by the covered entity to have occurred.
- The authorization has not been filled out completely, with respect to any applicable elements described below.
- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
- Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.



## Authorization to Release Health Records

Adolfo Housing Program for Former Foster Youth

### Records and Information Pertaining To

DATE:

LAST NAME:

FIRST NAME:

MIDDLE  
INITIAL:

SSN:

DATE OF BIRTH:

ADDRESS:

### Check mark the types of confidential information to be released

<input type="checkbox"/> Entire Record (Excludes HIV, Mental Health & Alcohol/Drug Info)	<input type="checkbox"/> Lab Tests	<input type="checkbox"/> Attendance Only Records
<input type="checkbox"/> Include HIV or AIDS Information	<input type="checkbox"/> Medication	<input type="checkbox"/> Consultation Reports/ Physician Orders
<input type="checkbox"/> Include Alcohol/Drug Information	<input type="checkbox"/> Treatment/ Personal Service Plan	<input type="checkbox"/> Progress Reports/Notes
<input type="checkbox"/> Include Mental Health Information	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric/Psychological Assessment/Testing Results
<input type="checkbox"/> Medical Records relating to _____	<input type="checkbox"/> Social History	<input type="checkbox"/> Billing or Payment Information
<input type="checkbox"/> Records from a specific visit or hospitalization (enter date and location)		
<input type="checkbox"/> Other		

### Send the Information to the following provider/agency or person

PROGRAM/AGENCY/OFFICE NAME:

COUNTY OF SACRAMENTO, DEPARTMENT OF HEALTH & HUMAN SERVICES / ILP

ADDRESS:

925 DEL PASO BLVD., SUITE 500, SACRAMENTO, CA 95815

TELEPHONE NUMBER:  
(916) 874-9715

FAX NUMBER:  
(916) 874-9280

CONTACT NAME (IF KNOWN):  
LAURIE HINSHAW

**Authorization will expire three years from signature date.**

**Purpose(s) for releasing this confidential health information:**

Determine eligibility for the Laverne Adolfo Housing program and related services.

**I agree that the County of Sacramento may send my health information as indicated above to the following agencies:**

Volunteers of America

Lutheran Social Services

**Important Note**

**Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.**

**HIV, Alcohol and Drug, and Mental Health Treatment:** These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. Re-disclosure of these records is not allowed, except in compliance with state or federal law or with your written permission. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

I understand that my representative or I may revoke this authorization to obtain, use and disclose my information at any time in writing. I understand this change will not affect information that has already been shared. I understand that this authorization is voluntary; that my health information may be protected under federal or state confidentiality laws. I understand that these federal or state laws may not apply to the person or organization receiving the information being shared. I understand that I may choose not to sign this authorization and this will not affect my ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if I am eligible to enroll in the Sacramento County Health program, I may not be able to show I qualify for these services.

**(If applicable)** I understand that County of Sacramento has been asked to provide a health care service to me (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if I choose not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to me.

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Full Legal Signature or Mark of Individual Date

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Full Legal Signature of Representative Relationship Date

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Signature of County Representative Date

If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

## Attachment A

### For releasing to more than one Program/Agency/Office:

Enter who you want to share your health information with:

PROGRAM/AGENCY/OFFICE NAME <b>VOLUNTEERS OF AMERICA (VOA)</b>		
ADDRESS: 10566 PETER A. MCCUEN, MATHER CA 95655		
TELEPHONE NUMBER: (916) 369-8394	FAX NUMBER: (916) 368-7745	CONTACT NAME (IF KNOWN): <b>LYNDA LEWIS</b>

PROGRAM/AGENCY/OFFICE NAME <b>LUTHERAN SOCIAL SERVICES (LSS)</b>		
ADDRESS: 2980 35 <sup>TH</sup> STREET, SACRAMENTO, CA 95817		
TELEPHONE NUMBER: (916) 453-2900 EXT. 217	FAX NUMBER: (916) 453-2904	CONTACT NAME (IF KNOWN): <b>SUE LALIBERTE</b>

PROGRAM/AGENCY/OFFICE NAME <b>DEPARTMENT OF HEALTH &amp; HUMAN SERVICES (DHHS-ILP)</b>		
ADDRESS: 925 DEL PASO BLVD., SACRAMENTO, CA 95815		
TELEPHONE NUMBER: (916) 874-9715	FAX NUMBER: (916)874-9280	CONTACT NAME (IF KNOWN): <b>Laurie Hinshaw</b>

PROGRAM/AGENCY/OFFICE NAME <b>CASEY GREAT START YOUNG ADULT PROGRAM</b>		
ADDRESS: 770 L. STREET SUITE 1420, SACRAMENTO, CA 95814		
TELEPHONE NUMBER: (916) 503-2953	FAX NUMBER: (916) 442-1735	CONTACT NAME (IF KNOWN): <b>DEWAYNE NORRIS</b>

PROGRAM/AGENCY/OFFICE NAME <b>SACRAMENTO EMPLOYMENT AND TRAINING AGENCY (SETA)</b>		
ADDRESS: 925 DEL PASO BOULEVARD, SACRAMENTO, CA 95815		
TELEPHONE NUMBER: (916) 263-3800	FAX NUMBER: (916) 263-3825	CONTACT NAME (IF KNOWN):

**Attachment A** (Continued)

**For releasing to more than one Program/Agency/Office:**

PROGRAM/AGENCY/OFFICE NAME DEPARTMENT OF PROBATION		
ADDRESS: 5445 LAUREL HILLS DR., SACRAMENTO, CA 95841		
TELEPHONE NUMBER: (916) 875-1685	FAX NUMBER: (916) 875-4605	CONTACT NAME (IF KNOWN): <b>RON BARROGA</b>

PROGRAM/AGENCY/OFFICE NAME WIND		
ADDRESS: 701 DIXIEANNE AVE, SACRAMENTO, CA 95815		
TELEPHONE NUMBER: (916) 443-8333	FAX NUMBER: (916)920-2280	CONTACT NAME (IF KNOWN): <b>MELISSA BINGER</b>

**I agree that the County of Sacramento may send my health information as indicated above to the Program/Agency/Offices indicated in this Authorization:**

\_\_\_\_\_  
Full Legal Signature or Mark of Individual Date

\_\_\_\_\_  
Full Legal Signature or Mark of Representative Date

\_\_\_\_\_  
Full Legal Signature of County Representative Date



**Mental Health Services**

Does applicant have any mental health issues?  Yes  No (If no, no psychological evaluation is needed)

Has the applicant ever received mental health services?  Yes  No

Are they still receiving services?  Yes  No

If yes, for what? \_\_\_\_\_

Have psychotropic medications ever been prescribed for this applicant?  Yes  No

Has applicant ever been hospitalized for the treatment of a mental illness?  Yes  No

**Referral** (check the appropriate box(s) below)

- From my research and to the best of my knowledge, this applicant meets all of the criteria outlined in the Application.
- I was unable to find out if the applicant meets the criteria and believe further research may be needed.
- I am available to provide ongoing support to this youth.
- I am the primary ILP worker for this youth and will continue my involvement.

\_\_\_\_\_  
**Signature of Referring Person**

\_\_\_\_\_  
**Date**

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agency/Company: \_\_\_\_\_

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

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**NOTE: Letter(s) of Recommendation are strongly encouraged.**

**ADOLFO HOUSING SERVICES FOR FORMER FOSTER YOUTH**

*Contact information for applicant's current supportive services*

To be completed by the applicant, referring agency, or both.

**Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Do you have MediCal?** Yes / No

**ILP Case Worker**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Foster Care Social Worker**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Casey Great Start Youth Specialist**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Group Home Contact**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Therapist**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**SSI/Disability Case Worker**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**CalWORKs/General Assistance Case Worker**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

# COUNTY OF SACRAMENTO

## DISABILITY CERTIFICATION

### ***For Permanent Supportive Housing Programs (PSH)***

Effective August 2006, the list of qualified professionals who are able to document disabilities for permanent supportive housing has been expanded. Please see the list below.

#### For a ***Physical disability:***

- Licensed Medical Doctor
- Licensed Nurse Practitioner

#### For a ***Mental Health disability:***

- Licensed Medical Doctor
- Licensed Nurse Practitioner
- Licensed Psychiatrist
- Licensed Psychologist
- Licensed Clinical Social Worker (LCSW)
- Marriage Family Therapist (MFT)
- County Mental Health Clinician

#### For an ***Alcohol and/or Drug disability:***

- Licensed Medical Doctor
- Licensed Nurse Practitioner
- Licensed Psychiatrist
- Licensed Psychologist
- Licensed Clinical Social Worker (LCSW)
- Marriage Family Therapist (MFT)
- County Alcohol and Drug Clinician
- Certified Alcohol and Drug Counselor

# COUNTY OF SACRAMENTO

## DISABILITY CERTIFICATION

For SHP Permanent Supportive Housing Programs

*(Please complete all sections including signatures)*

1. Name of Client:

\_\_\_\_\_

2. I certify that the above named client is disabled, because:

The client is receiving Supplemental Security Income (SSI) benefits or has been determined to be eligible for SSI benefits.

*If you check box 2, you must attach a copy of the client's SSI determination letter and complete the signature section below.*

3. I certify that the above named client is disabled, because:

The client is not receiving SSI benefits but meets the following definition of disability:

“A person shall be considered to have a disability if such person (1) has a physical, mental, or emotional impairment which is expected to be of *long-continued and indefinite duration*; substantially impedes his or her ability to live independently; **and** is of such nature that such ability could be improved by more suitable housing conditions, or (2) has a developmental disability; or (3) has AIDS or conditions arising from its etiological effects.

Please complete and sign below to certify your choice in section 3. Certification must be signed by a qualified professional. (See the attached list to determine who is considered a qualified professional.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address

( ) \_\_\_\_\_  
Phone