

MEMORANDUM OF UNDERSTANDING

Between the

County of Fresno

and

Housing Authority of the City and County of Fresno

THIS MEMORANDUM OF UNDERSTANDING, hereinafter referred to as "MOU" or "Agreement" is made and entered into this _ day of June, 2021, between the COUNTY OF FRESNO, a Political Subdivision of the State of California, hereinafter referred to as "COUNTY," and FRESNO HOUSING AUTHORITY, a Public Agency hereinafter referred to as "FHA," whose address is 1331 Fulton Street, Fresno, CA 93721.

WITNESSETH:

WHEREAS, the Shelter Plus Care (SPC) Tenant-based Rental Assistance (TRA) Program is funded by Subtitle C, Section 421 Continuum of Care Program of the Stewart B. McKinney Homeless Assistance Act as amended by S. 896, The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009; and

WHEREAS, SPC program provides tenant based rental assistance and supportive services to individuals experiencing homelessness who are diagnosed with a disability, such as serious mental health issues; chronic substance use disorder; HIV and/or related diseases; physical health issues; and/or developmental disabilities; and

WHEREAS, FHA has agreed to set aside at least fifty-one (51) SPC certificates for COUNTY's Department of Behavioral Health (DBH) and its selected contractors; and

WHEREAS, COUNTY's DBH and its selected contractors have expressed commitment to providing supportive services for the referred SPC participants under such certificates; and

WHEREAS, it is to the mutual benefit of the parties hereto that FHA and COUNTY's DBH and its selected contractors collaborate for the provision of SPC TRA program services to aid individuals experiencing homelessness who are diagnosed with a disability, such as serious

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1 mental health issues; chronic substance use disorder; HIV and/or related diseases; physical health
2 issues; and/or developmental disabilities; and

3 WHEREAS, the purpose of this MOU is to clearly identify the roles and responsibilities of FHA
4 and COUNTY;

5 NOW, THEREFORE, the parties agree as follows:

6 **1. SERVICES**

7 A. COUNTY and FHA shall perform services and fulfill all responsibilities as set forth in
8 Exhibit A, "Shelter Plus Care Tenant-based Rental Assistance Program Scope of Work,"
9 attached hereto and by this reference incorporated herein and made part of this
10 Agreement.

11 B. COUNTY and FHA shall participate in monthly, or as needed, roundtable meetings
12 consisting of designated staff from both parties to discuss SPC requirements, data
13 reporting, training, discontinuation of supportive services for participants, policies and
14 procedures, overall program operations and any problems or foreseeable problems that
15 may arise.

16 C. Acknowledge COUNTY and FHA may request termination of housing assistance for a
17 SPC TRA program participant who is in violation of program requirements, and/or
18 conditions of occupancy.

19 D. Acknowledge FHA reserves the right to disperse SPC Certificate to other providers who
20 have a signed MOU, ability to utilize Certificates, and provide in-kind match.

21 E. Acknowledge that, if COUNTY and its selected contractors are unable to submit referrals
22 or provide the required in-kind match in supportive services, FHA will have the right to
23 reduce or eliminate allocated SPC TRA Certificates for COUNTY and its selected
24 contractors.

25 **2. TERM**

26 The term of this Agreement shall be for a period of three (3) years, commencing on the 1st day of
27 July, 2021 and terminating on the 30th day of June, 2024. This Agreement may be extended for two (2)
28 additional consecutive twelve (12) months periods upon written approval of both parties no later than

1 thirty (30) days prior to the first day of the next twelve (12) month extension period upon the same terms
2 and conditions herein set forth, unless written notice of non-renewal is given no later than sixty (60) days
3 prior to the close of the current Agreement term.

4 **3. TERMINATION**

5 A. Non-Allocation of Funds – The terms of this Agreement, and the services to be provided
6 hereunder, are contingent on the approval of funds by the appropriating government
7 agency. Should sufficient funds not be allocated, the services provided may be modified,
8 or this Agreement may be terminated by thirty (30) days advance written notice prior
9 given by one party to the other.

10 B. Breach of Contract – The COUNTY may immediately suspend or terminate this
11 Agreement in whole or in part, where in the determination of COUNTY there is:

12 i. A failure to comply with any term of this Agreement;

13 ii. A substantially incorrect or incomplete report submitted to COUNTY

14 C. Without Cause – Under circumstances other than those set forth above, this Agreement
15 may be terminated by FHA or COUNTY or COUNTY’s DBH Director, or designee, upon
16 giving thirty (30) days advanced written notice of an intention to terminate.

17 **4. COMPENSATION**

18 The supportive services conducted pursuant to the terms and conditions of this Agreement shall be
19 performed without the payment of any monetary consideration by FHA or COUNTY, one to the other.

20 **5. INDEPENDENT CONTRACTOR**

21 In performance of the work, duties, and obligations assumed by FHA under this Agreement, it is
22 mutually understood and agreed that FHA, including any and all of FHA’s officers, agents, and
23 employees will at all times be acting and performing as an independent contractor, and shall act in an
24 independent capacity and not as an officer, agent, servant, employee, joint venturer, partner, or
25 associate of COUNTY. Furthermore, COUNTY shall have no right to control or supervise or direct the
26 manner or method by which FHA shall perform its work and function. However, COUNTY shall retain the
27 right to administer this Agreement so as to verify that FHA is performing its obligations in accordance
28 with the terms and conditions thereof. FHA and COUNTY shall comply with all applicable provisions of

1 law and the rules and regulations, if any, of governmental authorities having jurisdiction over matters
2 which are directly or indirectly the subject of this Agreement.

3 Because of its status as an independent contractor, FHA shall have absolutely no right to
4 employment rights and benefits available to COUNTY employees. FHA shall be solely liable and
5 responsible for providing to, or on behalf of, its employees all legally required employee benefits. In
6 addition, FHA shall be solely responsible and save COUNTY harmless from all matters relating to
7 payment of FHA's employees, including compliance with Social Security, withholding and all other
8 regulations governing such matters. It is acknowledged that during the term of this Agreement, FHA may
9 be providing services to others unrelated to COUNTY into this Agreement.

10 **6. MODIFICATION**

11 Any matters of this Agreement may be modified from time to time by the written consent of all parties
12 without, in any way, affecting the remainder.

13 Notwithstanding the above, changes in addresses to which notices are to be sent may be made by
14 written approval of COUNTY's DBH Director or designee and FHA.

15 **7. NON-ASSIGNMENT**

16 Neither party shall assign, transfer, or subcontract this Agreement nor their rights or duties under
17 this Agreement without the prior written consent of the other party.

18 **8. HOLD-HARMLESS**

19 A. FHA agrees to indemnify, save, hold harmless, and at COUNTY'S request, defend the
20 COUNTY, its officers, agents, and employees from any and all costs and expenses
21 (including attorney's fees and costs), damages, liabilities, claims, and losses occurring or
22 resulting to COUNTY in connection with the performance, or failure to perform, by FHA,
23 its officers, agents, or employees under this Agreement, and from any and all costs and
24 expenses (including attorney's fees and costs), damages, liabilities, claims, and losses
25 occurring or resulting to any person, firm, or corporation who may be injured or
26 damaged by the performance, or failure to perform, of FHA, its officers, agents, or
27 employees under this Agreement.

1 B. COUNTY and FHA shall give timely notice to the other of any claim, demand, lien, or suit
2 coming to its knowledge which in any way might affect the other party and each party
3 shall have the right to participate in the defense of the same to the extent of its interest.
4 COUNTY and FHA recognize that the significant mutual benefits of this Agreement
5 depend upon close cooperation and good faith handling of matters subject to such
6 indemnification provisions.

7 **9. INSURANCE**

8 Without limiting the COUNTY's right to obtain indemnification from FHA or any third parties, FHA, at
9 its sole expense, shall maintain in full force and effect, the following insurance policies or a program of
10 self-insurance, including but not limited to, an insurance pooling arrangement or Joint Powers
11 Agreement (JPA) throughout the term of the Agreement:

12 A. Commercial General Liability

13 Commercial General Liability insurance with limits of not less than Two Million Dollars
14 (\$2,000,000.00) per occurrence and an annual aggregate of Four Million Dollars
15 (\$4,000,000.00). This policy shall be issued on a per occurrence basis. COUNTY may
16 require specific coverages including completed operations, products liability, contractual
17 liability, Explosion-Collapse-Underground, fire legal liability or any other liability insurance
18 deemed necessary because of the nature of this contract.

19 B. Automobile Liability

20 Comprehensive Automobile Liability Insurance with limits of not less than One Million
21 Dollars (\$1,000,000.00) per accident for bodily injury and for property damages.
22 Coverage should include any auto used in connection with this Agreement.

23 C. Professional Liability

24 If FHA employs licensed professional staff (e.g., Ph.D., R.N., L.C.S.W., M.F.C.C.) in
25 providing services, Professional Liability Insurance with limits of not less than One Million
26 Dollars (\$1,000,000.00) per occurrence, Three Million Dollars (\$3,000,000.00) annual
27 aggregate. FHA agrees that it shall maintain, at its sole expense, in full force and effect
28

1 for a period of three (3) years following the termination of this Agreement, one or more
2 policies of professional liability insurance with limits of coverage as specified herein.

3 D. Worker's Compensation

4 A policy of Worker's Compensation Insurance as may be required by the California Labor
5 Code.

6 E. Cyber Liability (if applicable)

7 Cyber Liability Insurance, with limits not less than \$2,000,000 per occurrence or claim,
8 \$2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and
9 obligations as is undertaken by FHA in this Agreement and shall include, but not be
10 limited to, claims involving infringement of intellectual property, including but not limited to
11 infringement of copyright, trademark, trade dress, invasion of privacy violations,
12 information theft, damage to or destruction of electronic information, release of private
13 information, alteration of electronic information, extortion and network security. The policy
14 shall provide coverage for breach response costs as well as regulatory fines and
15 penalties as well as credit monitoring expenses with limits sufficient to respond to these
16 obligations.

17 F. Molestation

18 Sexual abuse / molestation liability insurance with limits of not less than One Million
19 Dollars (\$1,000,000.00) per occurrence, Two Million Dollars (\$2,000,000.00) annual
20 aggregate. This policy shall be issued on a per occurrence basis.

21 Additional Requirements Relating to Insurance

22 FHA shall obtain endorsements to the Commercial General Liability insurance naming the County of
23 Fresno, its officers, agents, and employees, individually and collectively, as additional insured, but only
24 insofar as the operations under this Agreement are concerned. Such coverage for additional insured
25 shall apply as primary insurance and any other insurance, or self-insurance, maintained by COUNTY, its
26 officers, agents and employees shall be excess only and not contributing with insurance provided under
27 CONTRACTOR's policies herein. This insurance shall not be cancelled or changed without a minimum
28 of thirty (30) days advance written notice given to COUNTY.

1 FHA hereby waives its right to recover from COUNTY, its officers, agents, and employees any
2 amounts paid by the policy of worker's compensation insurance required by this Agreement.
3 CONTRACTOR is solely responsible to obtain any endorsement to such policy that may be necessary
4 to accomplish such waiver of subrogation, but FHA's waiver of subrogation under this paragraph is
5 effective whether or not FHA obtains such an endorsement.

6 Within Thirty (30) days from the date FHA signs and executes this Agreement, FHA shall provide
7 certificates of insurance and endorsement as stated above for all of the foregoing policies, as required
8 herein, to the County of Fresno, (Name and Address of the official who will administer this contract),
9 stating that such insurance coverage have been obtained and are in full force; that the County of
10 Fresno, its officers, agents and employees will not be responsible for any premiums on the policies; that
11 such Commercial General Liability insurance names the County of Fresno, its officers, agents and
12 employees, individually and collectively, as additional insured, but only insofar as the operations under
13 this Agreement are concerned; that such coverage for additional insured shall apply as primary
14 insurance and any other insurance, or self-insurance, maintained by COUNTY, its officers, agents and
15 employees, shall be excess only and not contributing with insurance provided under FHA's policies
16 herein; and that this insurance shall not be cancelled or changed without a minimum of thirty (30) days
17 advance, written notice given to COUNTY.

18 **10. CONFIDENTIALITY**

19 All services performed by FHA under this Agreement shall be in strict conformance with all
20 applicable Federal, State of California and/or local laws and regulations relating to confidentiality.

21 **11. NON-DISCRIMINATION**

22 During the performance of this Agreement, FHA shall not unlawfully discriminate against any
23 employee or applicant for employment, or recipient of services, because of race, religion, color, national
24 original, ancestry, physical disability, medical condition, marital status, age, or gender, pursuant to all
25 applicable State of California and Federal statutes and regulations.

26 **12. CONFLICT OF INTEREST**

27 No officer, agent, or employee of COUNTY who exercises any function or responsibility for planning
28 and carrying out the services provided under this Agreement shall have any direct or indirect personal

1 financial interest in this Agreement. FHA shall comply with all Federal, State of California, and local
2 conflict of interest laws, statutes, and regulations, which shall be applicable to all parties and
3 beneficiaries under this Agreement and any officer, agent, or employee of COUNTY.

4 **13. COMPLIANCE WITH STATE REQUIREMENTS**

5 FHA recognized that COUNTY operates its mental health system under an agreement with the State
6 Department of Health Care Services and that under said agreement the State of California imposes
7 certain requirements on COUNTY and its subcontractors. FHA shall adhere to all State of California
8 requirements, including those identified in Exhibit B, attached hereto and by this reference incorporated
9 herein.

10 **14. AUDITS AND INSPECTIONS**

11 FHA shall at any time during business hours, and as often as COUNTY may deem necessary, make
12 available to COUNTY for examination all of its records and data with respect to the matters covered by
13 this Agreement. FHA shall, upon request by COUNTY, permit COUNTY to audit and inspect all such
14 records and data necessary to ensure FHA's compliance with the terms of this Agreement.

15 **15. NOTICES**

16 The persons having authority to give and receive notices under this Agreement and their addresses
17 include the following:

18 **COUNTY OF FRESNO**

FHA

19 Director, Fresno County

Executive Director

20 Department of Behavioral Health

Fresno Housing Authority

21 1925 E. Dakota Ave.

1331 Fulton Street

22 Fresno, CA 93276

Fresno, CA 93721

23 Any and all notices between COUNTY and FHA under this Agreement or by law shall be in writing and
24 be deemed duly served when personally delivered to one of the parties, or in lieu of such personal
25 service, when deposited in the United States Mail, postage prepaid, addressed to such party.

26 **16. SEVERABILITY**

27 The provisions of this Agreement are severable. The invalidity or unenforceability of any one
28 provision of this Agreement shall not affect the other provisions.

1 **17. DATA SECURITY**

2 For the purpose of preventing the potential loss, misappropriation or inadvertent access, viewing,
3 use, or disclosure of COUNTY data including sensitive or personal client information; abuse of COUNTY
4 resources; and/or disruption to COUNTY operations, individuals and/or agencies that enter into a
5 contractual relationship with COUNTY for the purpose of providing services under this Agreement must
6 employ adequate data security measures to protect the confidential information provided to
7 CONTACTOR by COUNTY, including but not limited to the following:

8 A. FHA-Owned Mobile, Wireless, or Handheld Devices

9 i. FHA may not connect to COUNTY networks via personally owned mobile,
10 wireless, or handheld devices, unless the following conditions are met:

- 11 1. FHA has received authorization by COUNTY for telecommuting purposes;
- 12 2. Current virus protection software is in place;
- 13 3. Mobile device has the remote wipe feature enabled; and
- 14 4. A secure connection is used.

15 B. FHA-Owned Computers or Computer Peripherals

16 i. FHA may not bring FHA-owned computers or computer peripherals into COUNTY
17 for use without prior authorization from COUNTY’s Chief Information Officer,
18 and/or designee(s), including but not limited to mobile storage devices. If data is
19 approved to be transferred, data must be stored on a secure server approved by
20 COUNTY and transferred by means of a Virtual Private Network (VPN)
21 connection, or another type of secure connection. Said data must be encrypted.

22 C. COUNTY-Owned Computer Equipment

23 i. FHA may not use COUNTY computers or computer peripherals on non-COUNTY
24 premises without prior authorization from the COUNTY’s Chief Information
25 Officer, and/or designee(s).

26 D. FHA may not store COUNTY’s private, confidential, or sensitive data or any hard-disk
27 drive, portable storage device, or remote storage installation unless encrypted.

- 1 E. FHA shall be responsible to employee strict controls to ensure the integrity and security
2 of COUNTY's confidential information and to prevent unauthorized access, viewing, use,
3 or disclosure of data maintained in computer files, program documentation, data
4 processing systems, data files, and data processing equipment which stores or
5 processes COUNTY data internally and externally.
- 6 F. Confidential client information transmitted to one party by the other by means of
7 electronic transmissions must be encrypted according to Advanced Encryption Standards
8 (AES) of 128 BIT or higher. Additionally, a password or passphrase must be utilized.
- 9 G. FHA is responsible to immediately notify COUNTY of any violations, breaches, or
10 potential breaches of security related to COUNTY's confidential information, data
11 maintained in computer files, program documentation, data processing systems, data
12 files, and data processing equipment which stores or processes COUNTY data internally
13 or externally.
- 14 H. COUNTY shall provide oversight to FHA's response to all incidents arising from a
15 possible breach of security related to COUNTY's confidential client information provided
16 to FHA. FHA will be responsible to issue any notification to affected individuals as
17 required by law or as deemed necessary by COUNTY in its sole discretion. FHA will be
18 responsible for all costs incurred as a result of providing the required notification.

19 **18. PROHIBITION OF PUBLICITY**

20 None of the funds, materials, property, or services provided directly or indirectly under this
21 Agreement shall be used for FHA's advertising, fundraising, or publicity (i.e. purchasing of tickets/tables,
22 silent auction donations, etc.) for the purpose of self-promotion.

23 Notwithstanding the above, publicity of the services described in Section 1 and Exhibit A of this
24 Agreement shall be allowed as necessary to raise public awareness about the availability of such
25 specific services when approved in advance by COUNTY's DBH Director or their designee and at a cost
26 to be provided in Exhibit A for such items as written/printed materials, the use of media (i.e. radio,
27 television, newspapers) and any other related expense(s).

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1 **19. GOVERNING LAW**

2 The parties agree that for the purpose of venue, performance under this Agreement is in Fresno
3 County, California.

4 The rights and obligations of the parties and all interpretation and performance of this Agreement
5 shall be governed in all respects by the laws of the State of California.

6 **20. DISCLOSURE OF SELF-DEALING TRANSACTIONS**

7 This provision is only applicable if the FHA is operating as a corporation (a for-profit or non-profit
8 corporation) or if during the term of the agreement, the FHA changes its status to operate as a
9 corporation.

10 Members of the FHA's Board of Directors shall disclose any self-dealing transactions that they are a
11 party to while FHA is providing goods or performing services under this agreement. A self-dealing
12 transaction shall mean a transaction to which the FHA is a party and in which one or more of its
13 directors has a material financial interest. Members of the Board of Directors shall disclose any self-
14 dealing transactions that they are a party to by completing and signing a Self-Dealing Transaction
15 Disclosure Form, attached hereto as Exhibit I and incorporated herein by reference, and submitting it to
16 the COUNTY prior to commencing with the self-dealing transaction or immediately thereafter.

17 **21. ELECTRONIC SIGNATURE**

18 The parties agree that this Agreement may be executed by electronic signature as provided in this
19 section. An "electronic signature" means any symbol or process intended by an individual signing this
20 Agreement to represent their signature, including but not limited to (1) a digital signature; (2) a faxed
21 version of an original handwritten signature; or (3) an electronically scanned and transmitted (for example
22 by PDF document) of a handwritten signature. Each electronic signature affixed or attached to this
23 Agreement (1) is deemed equivalent to a valid original handwritten signature of the person signing this
24 Agreement for all purposes, including but not limited to evidentiary proof in any administrative or judicial
25 proceeding, and (2) has the same force and effect as the valid original handwritten signature of that person.
26 The provisions of this section satisfy the requirements of Civil Code section 1633.5, subdivision (b), in the
27 Uniform Electronic Transaction Act (Civil Code, Division 3, Part 2, Title 2.5, beginning with section 1633.1).
28 Each party using a digital signature represents that it has undertaken and satisfied the requirements of

1 Government Code section 16.5, subdivision (a), paragraphs (1) through (5), and agrees that each other
2 party may rely upon that representation. This Agreement is not conditioned upon the parties conducting the
3 transactions under it by electronic means and either party may sign this Agreement with an original
4 handwritten signature.

5 **22. ENTIRE AGREEMENT**

6 This Agreement, including all Exhibits, constitutes the entire agreement between FHA and COUNTY
7 with respect to the subject matter hereof and supersedes all previous agreements, negotiations,
8 proposals, commitments, writings, advertisements, publications, and understandings of any nature
9 whatsoever unless expressly included in this Agreement.

10
11 Exhibit A – Scope of Work

12 Exhibit B – Compliance with State Medi-Cal Requirements

13 Exhibit C – Accepted Match Form

14 Exhibit D – Application for Initial Occupancy

15 Exhibit E – HMIS Data Collection Form

16 Exhibit F – HMIS – Release of Information

17 Exhibit G – Participant Provider Agreement

18 Exhibit H – FMCoC – Release of Information

19 Exhibit I – Self-Dealing Transaction Disclosure Form

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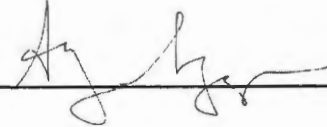
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1 IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and
2 year first hereinabove written.

3
4 **CONTRACTOR:**
5 **HOUSING AUTHORITY OF THE CITY**
6 **AND COUNTY OF FRESNO**

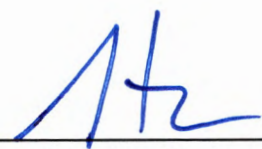
7 By:  _____

8
9 Print Name: Angelina Nguyen
10
11 Title: Interim CEO
12 Chief Executive Officer, or
13 President, or any Vice President

14
15
16
17
18
19 Mailing Address:
20 Fresno Housing Authority
21 1331 Fulton Street
22 Fresno, CA 93727-2014
23 Phone No: 559-443-8400
24 Contact: Doreen Eley
25 Shelter Plus Care Program Manager

26 Fund/Subclass: 0001/10000
27 Organization: 5630299
28 Account #: 7295/0

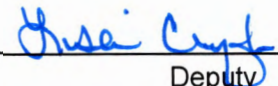
COUNTY OF FRESNO:



Steve Brandau, Chairman
of the Board of Supervisors of the
County of Fresno

Date: June 22, 2021

ATTEST:
Bernice E. Seidel
Clerk of the Board of Supervisors
County of Fresno, State of California

By:  _____
Deputy

Date: June 22, 2021

Shelter Plus Care Tenant-based Rental Assistance Program

Scope of Work

I. Definitions:

- Coordinated Entry System (CES): Community-wide system that facilitates coordination and management of resources and services to ensure all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.
- Document Ready: In possession of the required documentation to apply and qualify for the specified program.
- Homelessness:
 - o Literally Homeless –
 - Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
 - o Fleeing/Attempting to Flee Domestic –
 - Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking or human trafficking; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing

- Homeless Management Information System (HMIS): A HUD-mandated information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.
- Fresno Madera Continuum of Care (FMCoC): A homeless housing and services delivery system comprised of service providers, government entities, non-profits, businesses, and community members that facilitates coordinated, unduplicated and seamless services for the community's homeless population.
- Permanent Supportive Housing (PSH): Permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.

II. Program Description:

The Shelter Plus Care (SPC) Tenant-based Rental Assistance (TRA) Program links rental assistance to supportive services for persons experiencing homelessness who have been diagnosed with a disability. Participants will receive rental assistance from the Fresno Housing Authority (FHA) and supportive services from COUNTY's Department of Behavioral Health (DBH) and/or its selected service contractors. Service levels will be equivalent to or in excess of 25% of the rental assistance provided by FHA.

TRA provides grants that permit participants to choose housing of an appropriate size in which to reside. FHA requires participants to live in the same unit for the first year; they will retain their rental assistance if they move into different units within Fresno County thereafter.

III. Eligibility Requirements:

1. Participants must be:
 - a. experiencing homelessness (if over the age of 18)
 - b. diagnosed with a disability such as a serious mental health illness, chronic substance abuse, physical health disability, and/or developmental disability
 - c. eligible for mental health services and/or supportive services with an assigned case manager through DBH or its service provider

- d. document ready as described in Section IV “Required Documentation”
 - e. willing to sign a Release of Information (ROI) between DBH and FHA on an annual basis
2. Persons served must complete the prioritization process via an assessment tool and be enrolled into HMIS.
 3. Persons served must be referred through CES via a community matcher/coordinator from FMCoC.

IV. Required Documentation:

1. The person served and all other household members must have the required documentation:

Current within 60 Days of Application Submission:

- a. Accepted Match Form (Exhibit C)
- b. Application for Initial Occupancy (Exhibit D)
- c. Birth Certificate
- d. General Release of Information
- e. Government Issued Photo-Identification Card
- f. HMIS Data Collection Form (Exhibit E)
- g. HMIS ROI (Exhibit F)
- h. Participant Provider Agreement (Exhibit G)
- i. ROI with DBH, FHA, and all FMCoC affiliated agencies (Exhibit H)
- j. Social Security Card

Current within 30 Days of Application Submission:

- a. Disability Certification
 - b. FMCoC Homeless Verification and Letter
 - c. Proof of Income (if applicable)
2. Copies of the documents are accepted with the exception of the identification card.
 3. Each form is to be completed as per the instructions on the respective form and in conformance to SPC regulations. COUNTY and FHA shall provide and attach all necessary supporting documentation as indicated within each form to FHA’s designated staff.

V. COUNTY Responsibilities:

COUNTY and its selected contractors shall:

1. Operate on the Housing First model in its delivery of services. Housing First is a philosophy that homelessness can be most efficiently ended by providing someone with access to safe, decent, and affordable housing. Although an individual experiencing homelessness may benefit from supportive services such as mental health or substance abuse counseling, participation in these services is not a prerequisite to access housing or a condition of maintaining it. In fact, the stability that a housing unit provides bolsters a tenant's ability to participate in these services.
2. Provide SPC program outreach to eligible persons as defined in Section III "Eligibility Requirements;"
3. Refer eligible persons to SPC TRA program through CES;
4. Assist program participants in securing housing using the SPC TRA certificate;
5. Upon advisement of SPC TRA availability, COUNTY's designated DBH staff, FHA staff, and FMCoC CES staff will work together to find appropriate referrals from FMCoC By Name List using FMCoC priority system. Should there be no appropriate referrals, DBH staff may submit eligible individuals/families to CES for possible match to SPC TRA;
6. Ensure In-Kind Match Report is submitted to FHA by the 5th of every month;
7. Identify DBH staff as liaisons between FHA and COUNTY. Said individuals are responsible for:
 - a. Cash match reporting and maintaining supporting documentation;
 - b. Reviewing the referrals for pertinent documentation;
 - c. Eligibility;
 - d. Collaborating with CES staff for referrals to SPC TRA;
 - e. Submitting requests for SPC program training for staff of COUNTY and its selected contractors as needed; and
 - f. Informing FHA if there is a liaison staff change.
8. Ensure SPC referral is signed by DBH Director or designee.

9. Provide confidential on-going case management and/or supportive services to participants.
 - a. Case management services must be offered for at least six (6) months after participant receives housing.
 - b. Participants may be considered for discontinuation of case management services after six (6) months of participation in which they demonstrate the ability to live independently. Participant would maintain contact with DBH Housing Team for supportive services.
 - c. In the event participant begins to decompensate, the DBH SPC Housing Coordinator will re-link participant to case management services.
 - d. Participants will be encouraged to remain engaged in mental health and/or medication management services.
 - e. The parties agree that supportive services provided by COUNTY and its selected contractor may be in the form of treatment, therapy, crisis intervention, medication support, residential treatment, inpatient psychiatric care, vocational rehabilitation, mental health services, and other services mutually agreed to be considered supportive services. The parties agree that FHA shall make the final determination of whether a service is considered a supportive service;
10. Ensure supportive services are equivalent or in excess of twenty-five (25) percent of the amount paid in SPC Rental Assistance Payment (RAP) by FHA for the operating year, for all SPC participants referred.
11. Complete an addendum to this MOU annually, detailing the grant number, operating term, prospective services to be provided with the amounts for each (see attached).
12. Collect universal information for purposes of reporting on the HUD Annual Performance Report
13. Provide access of supportive services documentation to FHA to ensure SPC program compliance and accuracy of in-kind reporting.

VI. Role of COUNTY's DBH Housing Coordinator

14. Prior to SPC Enrollment, the assigned DBH Housing Coordinator:

- a. Receives a match referral of person served from the FMCoC Community Coordinator
 - b. Reviews the referrals and pertinent documentation; eligibility and submits the SPC referrals to the FHA designee.
 - c. DBH SPC Housing Coordinator waits for approval from FHA and then schedules with individual for certificate issue.
 - d. Provides outreach to persons experiencing homeless who are eligible for SPC.
 - e. Ensures that persons served meets all eligibility criteria for SPC and assists them in obtaining current documentation.
 - f. Schedules a case consultation with DBH Treatment Team's representative manager and person served. SPC is explained thoroughly and all questions are answered at the time of consult. The person served makes a final decision regarding their participation.
15. While Participant is Enrolled, the assigned DBH Housing Coordinator:
- a. Provides ongoing coordination of confidential wrap around and supportive services within the community.
 - b. Works with the identified case manager and other wrap around services for the retention of individual housing and supportive services engagement.
 - c. Maintains contact with participants at least once per month.
 - d. Maintains a participant file with accurate documentation of supportive and wrap around services, an Individual Service Plan (ISP), case notes, ROI tracking, and other documents deemed necessary to meet the SPC requirements.
 - e. Conducts regular landlord outreach/engagement activities and initiates referrals to assist with wrap around services such as housing searches to the DBH case managers and other community partners.
 - f. Assists participant in locating suitable housing to meet the needs of person served, including safety and affordability.

- g. Schedules a staffing with the DBH case manager and/or clinician at the three (3) and six (6) month marks to conduct a Housing Plan in which goals and stability needs are reviewed and addressed.

FHA Responsibilities:

FHA shall:

1. Operate on the Housing First model in its delivery of services. Housing First is a philosophy that homelessness can be most efficiently ended by providing someone with access to safe, decent, and affordable housing. Although an individual experiencing homelessness may benefit from supportive services such as mental health or substance abuse counseling, participation in these services is not a prerequisite to access housing or a condition of maintaining it. In fact, the stability that a housing unit provides bolsters a tenant's ability to participate in these services.
2. Administer SPC in compliance with applicable regulations;
3. Advise COUNTY's designated DBH staff and FMCoC CES staff of SPC TRA availability. CES staff will consult the By Name List for appropriate referrals using FMCoC priority system;
4. Coordinate participant intake;
5. Ensure SPC data and reports on HMIS are in compliance with FMCoC expectations;
6. Compile quarterly SPC data and reports on HMIS.
7. Provide technical assistance and training to DBH designated staff as needed;
8. Assist COUNTY and SPC participants in retaining rental housing assistance through advocacy;
9. Provide eligibility/annual re-certifications and Housing Quality Standards Inspections for SPC participants;
10. Monitor and updates monthly reports for COUNTY's in-kind supportive services match;
11. Identify FHA staff as a liaison between FHA and COUNTY; and
12. Process SPC participant termination for non-compliance with SPC Program regulations, including non-compliance with Participant-Service Provider Agreements as it pertains to

non-adherence to case management and subsequent non-compliance with lease requirements and/or criminal behavior.

COMPLIANCE WITH STATE MEDI-CAL REQUIREMENTS

CONTRACTOR shall be required to maintain organizational provider certification by the host county. A copy of this renewal certificate must be furnished to COUNTY within thirty (30) days of receipt of certificate from host county. The CONTRACTOR must meet Medi-Cal organization provider standards as stated below. It is acknowledged that all references to Organizational Provider and/or Provider below shall refer to the CONTRACTOR.

Medi-Cal Organizational Provider Standards

1. The organizational provider possesses the necessary license to operate, if applicable, and any required certification.
2. The space owned, leased or operated by the provider and used for services or staff meets local fire codes.
3. The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary and in good repair.
4. The organizational provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of beneficiaries and staff.
5. The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, and procedures for reporting unusual occurrences relating to health and safety issues.
6. The organizational provider maintains client records in a manner that meets applicable state and federal standards.
7. The organization provider has staffing adequate to allow the COUNTY to claim federal financial participation for the services the Provider delivers to beneficiaries, as described in Division 1, Chapter 11, Subchapter 4 of Title 9, CCR, when applicable.
8. The organizational provider has as head of service a licensed mental health professional or other appropriate individual as described in Title 9, CCR, Sections 622 through 630.
9. For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
 - A. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.
 - B. Drugs intended for external use only or food stuffs are stored separately from drugs for internal use.
 - C. All drugs are stored at proper temperatures, room temperature drugs at 59-86 degrees F and refrigerated drugs at 36-46 degrees F.

- D. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.
 - E. Drugs are not retained after the expiration date. IM multi-dose vials are dated and initialed when opened.
 - F. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.
 - G. Policies and procedures are in place for dispensing, administering and storing medications.
10. The COUNTY may accept the host county's site certification and reserves the right to conduct an on-site certification review at least every three years. The COUNTY may also conduct additional certification reviews when:
- The provider makes major staffing changes.
 - The provider makes organizational and/or corporate structure changes (example: conversion from a non-profit status).
 - The provider adds day treatment or medication support services when medications shall be administered or dispensed from the provider site.
 - There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
 - There is change of ownership or location.
 - There are complaints against the provider.
 - There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community.

SHELTER PLUS CARE APPLICATION FOR INITIAL OCCUPANCY

Head of Household Name: _____ Address: _____

Phone No.: _____ Message Phone No. _____ Message Contact Name: _____

Entity ID: _____ Anniversary Date: _____ Increment No. _____ Packet Due Date: _____

A. HOUSEHOLD COMPOSITION

	ADULTS (LEGAL NAMES)	RELATIONSHIP	RACE	DISABLED Y/N	SEX M / F	BIRTH DATE	SOCIAL SECURITY NO.
1		HEAD					
2		SPOUSE/ CO-HEAD					
3							
	CHILDREN (LEGAL NAMES)						
4							
5							
6							
7							
8							

ARE ANY ADULT FAMILY MEMBERS CURRENTLY ENROLLED AS A FULL TIME "or" PART-TIME STUDENT? YES NO
 If "yes" read and complete the following:
 Family Member's Name: _____ Full time Part time
 NAME OF SCHOOL: _____ ADDRESS: _____
 PHONE NUMBER: _____

If you are under the age of 24, not married, do not have dependents and are not a U.S. Veteran, you must pick up a "Student Verification Information Sheet" from our office or download one from our website at www.hafresno.org, and attach to this packet. If there is more than one adult attending school FT or PT, provide this information on a separate sheet of paper.

Are any family members a US Veteran? Yes No If "yes," who? _____

LIST BELOW ALL PERSONS WHO MOVED OUT IN THE PAST 12 MONTHS (INCLUDE DEATHS, MARRIAGES, PERMANENT PLACEMENT IN NURSING HOME, ETC.)

FULL NAME	RELATIONSHIP	DATE OF MOVE OUT	REASON

DO YOU ANTICIPATE ADDING OR REMOVING ANY MEMBERS OF YOUR HOUSEHOLD? YES NO
 IF "YES" EXPLAIN: _____

B. REASONABLE ACCOMONDATIONS List any family member (s) who require(s) reasonable accommodation and the type of accommodation being requested:

Household Member _____ Type of Accommodation Being Requested _____
 Household Member _____ Type of Accommodation Being Requested _____

C. DISCLOSURE OF CONFLICT OF INTEREST

Are you or any family member(s) related to any Housing Authority employee or Housing Authority Commissioner? Yes No
 If Yes, please provide the following:
 First and Last Name of Employee / Commissioner _____ Relationship _____

D. HOUSEHOLD INCOME - Failure to report income is grounds for termination. Call your worker if you have questions.

Family Member	FREQUENCY	CHILD SUPPORT	TAN/IGR	VETERANS	SSI/SSA	UNEMPLOYMENT	PENSION
	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	\$	\$	\$	\$	\$	\$
	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	\$	\$	\$	\$	\$	\$
	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	\$	\$	\$	\$	\$	\$
WAGES							
EMPLOYER:		DATE OF HIRE:		PH#:			
ADDRESS:		HOURLY RATE: \$		HRS WORKED WEEKLY:			
		PAY FREQUENCY: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> OTHER					
WAGES							
EMPLOYER:		DATE OF HIRE:		PH#:			
ADDRESS:		HOURLY RATE: \$		HRS WORKED WEEKLY:			
		PAY FREQUENCY: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> OTHER					
Are any earnings listed above the result of a job training program? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," explain: _____							
SELF-EMPLOYMENT Name: _____ Business Type: _____ Attach Profit/Loss Statement or IRS Schedule C.							
Assets/Cash							
Do you or a member of your family have checking, savings accounts, or any other type of asset? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Checking \$ _____		Acct No. _____		Bank Name _____		Address _____	
Savings \$ _____		Acct No. _____		Bank Name _____		Address _____	
Other Acct \$ _____		Type and Location: _____					
Checking \$ _____		Acct No. _____		Bank Name _____		Address _____	
Savings \$ _____		Acct No. _____		Bank Name _____		Address _____	
Other Acct \$ _____		Type and Location: _____					
Does any member of your household own other assets (Real estate property, Certificates of Deposits, Stocks, Bonds, or other investments)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" explain: _____							

E. OTHER INCOME

- 1. Do you receive Gifts, Contributions, Help from Family/Friends/Other? Yes No
If "yes" what amount \$ _____ and how often? Weekly Monthly Other
What for? _____
- 2. Does any family member work for someone who pays them cash? Yes No
If "yes" what amount \$ _____ and how often? Weekly Monthly Other
What for? _____
- 3. Have you or any family member received a lump sum payment in the past year? Yes No
If "yes" Explain: _____

F. TANF RECIPIENTS ONLY

- 4. Do you have any overpayment in TANF benefits? Yes No
If "yes" please attach your overpayment letter to this packet and state the amount of the overpayment here: \$ _____.
- 5. Are you or anyone in the household being **sanctioned** in your TANF benefits? Yes No
"Sanctioned" means you are receiving less than the full TANF grant normally awarded
If "yes" who? _____
If "yes" why? Fraud by a family member in connection with the welfare program Noncompliance with a work activities requirement.
 Failure to participate in an economic self-sufficiency program. Other: _____
 Penalty for non-cooperation with DA's Office
- 6. Are you timed out with your TANF benefits? Yes No
- 7. If there are any family members not on the cash grant, list their names and state the reason why they are not on the grant.
 MFB Baby (Child born after 9/1/97) Who? _____
 Minor not attending school or unsatisfactory grades: _____

G. EXPENSES

- 1. Have there been any changes during the past 12 months in your household expenses involving **MEDICAL EXPENSES**, including expenses related to the care of a disabled member, Medicare, medical insurance, medical assistance from the Welfare Department and outstanding medical bills to doctors, pharmacies or other medical facilities? Yes No
If "yes" explain: _____
- 2. Is the head of household or spouse paying out of pocket child care expenses for children under the age of 13 that enables him/her to work, attend school or participate in a job-training program? Yes No
If "yes" provide the name, address and phone number of the child care provider and the number of hours child care is provided on a separate sheet of paper and include it with this packet.

H. FAMILIES WITH DISABILITIES (Head of Spouse is permanently disabled).

Do you pay for a care attendant or pay for any equipment for a disabled member of the family necessary to permit that person or someone else in the family to work? Yes No
If "yes" describe the expenses: _____

I. ELDERLY / DISABLED FAMILIES ONLY (Head or Spouse must be at least 62 years of age or permanently disabled).

What is your Medicare premium? \$ _____

If you have any other kind of medical insurance, give policy number and agent's name:

Policy Number: _____ Agent: _____

Medical insurance premium that you pay monthly is \$ _____.

If you have any outstanding medical bills on which you are paying that are not covered by medical insurance, describe them here: _____

If you expect to have any medical expenses during the next 12 months that are not covered by medical insurance, list annual amount: \$ _____

J. PRIVACY ACT STATEMENT

The information on these forms is being collected by the Department of HUD to determine an applicant's/participant's eligibility, the recommended unit size, and the amount of contribution by the tenant(s). It will be used to provide the basis for managing the programs covered by this form, for protecting the government's financial interest, and for verifying the accuracy of the information furnished. It may be released to appropriate federal, state and local agencies when relevant to civil, criminal or regulatory investigators or prosecutors. Failure to provide information may result in a delay or rejection of your eligibility approval or termination of a participant's assistance. The department is authorized to ask for this information by the U.S. Housing Act of 1937 as amended, 42 U.S.C., 1437 et seq, the Housing and Community Development Amendments of 1981, P.L. 97.35.85 Stat, 348.408.

APPLICANT / TENANT CERTIFICATION

1. **GIVING TRUE AND COMPLETE INFORMATION:** I/We certify that all information provided on household composition, income, family assets and items for allowances and deductions are true and complete to the best of my/our knowledge.
2. **CHANGES IN INCOME OR HOUSEHOLD COMPOSITION:** I/We know that I/We are required to report immediately any changes in income, or when a person moves out of the unit. I/We understand that any changes to my family composition (except for the birth, adoption, or court-awarded custody of a child) must be approved by the Housing Authority BEFORE additional family members may move in. I/We understand that all changes in the income of any family member of the household must be reported within 30 calendar days of the change. Any changes in the household members must be reported to the Housing Authority within 10 business days from the date of the change.
3. **NO DUPLICATE RESIDENCE OR ASSISTANCE:** I/We certify that I/We have disclosed where I/we received any previous Federal Housing Assistance and whether or not money is owed. I/We certify that for this previous assistance I/we did not commit any fraud, knowingly misrepresent any information, or vacate the unit in violation of the lease.
4. **COOPERATION:** I/We know I/We are required to cooperate in supplying all information needed to determine my/our eligibility, level of benefits, or verify my/our true circumstances. Cooperation includes attending prescheduled meetings. Supplying false, incomplete, or inaccurate information is grounds for termination of housing assistance.
5. **CRIMINAL AND ADMINISTRATIVE ACTIONS FOR FALSE INFORMATION:** I/We understand that knowingly supplying false, incomplete, or inaccurate information is punishable under Federal or State criminal law. I/We understand that knowingly supplying false, incomplete, or inaccurate information is grounds for termination of housing assistance.
6. **RELEASE OF INFORMATION:** I the undersigned, acknowledge that I have received a copy of these SPC Contract of Participation. Furthermore, I have read and understood these obligations and failure to comply with any of them may result in the cancellation of my assistance.
7. **SPC CONTRACT OF PARTICIPATION:** To receive housing assistance, each recipient must be lawfully within the United States. "I certify, under penalty of perjury, that to the best of my knowledge I am lawfully within the United States. The responsible adult must sign for all family members under 18 years of age.
8. **STATEMENT OF FAMILY OBLIGATIONS:** I, the undersigned, acknowledge that I have received a copy of these Family Obligations. Furthermore, I have read and understood these obligations and failure to comply with any of them may result in the cancellation of my assistance.
9. **GROUND FOR DENIAL OR TERMINATION BY THE HOUSING AUTHORITY:** The Housing Authority may, at any time, deny program assistance for any applicant, or terminate program assistance for a participant. I have read the attached information and understand my assistance can be cancelled for the reasons listed.
10. **CONSENT FOR RELEASE OF INFORMATION:** I hereby authorize you to release to the Housing Authority of the City and County of Fresno, California, information regarding verification of family composition and family income requested by them. In the event I should vacate the premises prior to full settlement of incurred obligations, my forwarding address is also to be released to the Housing Authority.
11. **MOVING PROCEDURES:** I/We have been informed that I/We must contact the Housing Authority before I/We move from my/our current unit. If I/We fail to provide a 30-day written notice, I/we are aware that my/our assistance may be cancelled.

APPLICANT CERTIFICATION

UNDER PENALTY OF PERJURY, I/we certify that the information given in Sections A through I is accurate and complete to the best of my/our knowledge and belief. I/We have read and understand the above Applicant/Tenant Certification. I/We understand any attempt to obtain Shelter Plus Care housing by providing false information, impersonation, failure to disclose, or other fraud (and any act of assistance to such attempt) is a crime punishable under federal law. Warning: 18 U.S.C. 1000 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing any false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than \$10,000, imprisoned for not more than five years, or both.

_____ Signature of Head of Household	_____ Date	_____ Signature of Spouse or Co-Head	_____ Date
_____ Signature of Other Adult 18 or over	_____ Date	_____ Signature of Other Adult 18 or over	_____ Date
_____ Signature of Other Adult 18 or over	_____ Date	_____ Signature of Other Adult 18 or over	_____ Date

Authorization for the Release of Information/

U.S. Department of Housing
and Urban Development
Office of Public and Indian Housing

Privacy Act Notice

To the U.S. Department of Housing and Urban Development (HUD)
And the Housing/Agency/Authority (HA)

PHA requesting release of information:

Housing Authorities of the City and County of Fresno
PO Box 11985
Fresno CA 93776-1985

IHA requesting release of information:

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes and to HA's for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. Private owners may not request or receive information authorized by this form.

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form

PHA-owned rental public housing
Turnkey III Home Ownership Opportunities
Mutual Help Home Ownership Opportunity
Section 23 and 19(c) leased housing
Section 23 Housing Assistance Payments
HA-owned rental Indian housing
Section 8 Rental Certificate
Section 8 Rental Voucher
Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information to be Obtained

State Wage Information Collection Agencies: (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only)(This consent is limited to the wage and self employment information and payments of retirement income as referenced Section 6103(1)(7)(A) of the Internal Revenue Service Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to earned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Original is retained by the requesting organization.

Ref. Handbooks 7420.7, 7420.8, & 7420.1

Form HUD 9886 (7/94)

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Signature of Head of Household Date

Social Security Number (if any) of Head of Household

Signature of Other Family Member over age 18 Date

Signature of Spouse or Co-Head Date

Signature of Other Family Member over age 18 Date

Signature of Other Family Member over 18 Date

Signature of Other Family Member over age 18 Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. Seq.) Title VI of the Civil Rights Act of 1964 (42 U.S.S. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs to protect the Government's financial interest, local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members six years and older, have and use. Giving the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

Original is retained by the requesting organization.

ref. Handbooks 7420.7, 7420.8, &7465.1

Form HUD 9886 (7/94)

STATEMENT OF FAMILY OBLIGATIONS

Family obligations for continued assistance in a Shelter Plus Care are as follows:

1. Purpose. This section states the obligations of a participant family under the program.
2. Supplying required information -(1) The family must supply any information that the Public Housing Authority(PHA) or Housing and Urban Development(HUD) determines is necessary in the administration of the program, including any requested certification release or other documentation.
3. The family must supply any information requested by the PHA or HUD for use in a regularly scheduled reexamination or interim reexamination of family income and composition in accordance with HUD requirements.
4. The family must disclose and verify social security numbers (as provided by part 5, subpart b, of this title) and must sign and submit consent forms for obtaining information in accordance with part 5, sub 6 of this title.
5. Any information supplied by the family must be true and complete.
6. Housing Quality Standards (HQS) breach caused by family. The family is responsible for any HQS breach caused by the family as described in CFR 982.404 (b).
7. Allowing PHA inspection. The family must allow the PHA to inspect the unit at reasonable times and after reasonable notice.
8. Violation of lease. The family may not commit any serious or repeated violation of the lease.
9. Family notice of move or lease termination. The family must notify the PHA and the owner before the family moves out of the unit, or terminates the lease on notice to the owner. See CFR 982.314 (d).
10. Owner eviction notice. The family must promptly give the PHA a copy of any owner eviction notice.
11. Use and occupancy of unit. -(1) The family must use the assisted unit for residence by the family. The unit must be the family's only residence.
12. The composition of the assisted family residing in the unit must be approved by the PHA. The family must promptly inform the PHA of the birth, adoption or court-awarded custody of a child. The family must request PHA approval to add any other family member as an occupant of the unit. No other person [i.e., nobody but members of the assisted family] may reside in the unit (except for a foster child or live-in aide as provided in paragraph (h)(4) of this section).
13. The family must promptly notify the PHA if any family member no longer resides in the unit.
14. If the PHA has given approval, a foster child or a live-in-aide may reside in the unit. The PHA has the discretion to adopt reasonable policies concerning residence by a foster child or a live-in-aide, and defining when PHA consent may be given or denied. *(Continued on Next Page)*
15. Members of the household may engage in legal profit making activities in the unit, but only if such activities are incidental to primary use of the unit for residence by members of the family.
16. The family must not sublease or leave the unit.
17. The family must not assign the lease or transfer the unit.
18. Absence from the unit. The family must supply any information or certification requested by the PHA to verify that the family is living in the unit, or relating to family absence from the unit, including any PHA-requested information or certification on the purposes of family absence from the unit.
19. Interest in unit. The family not own or have any interest in the unit.
20. Fraud and other program violation. The members of the family must not commit fraud, bribery or any other corrupt or criminal act in connection with the programs.
21. Crime by household members. The members of the household may not engage in drug-related criminal activity or violent criminal activity or other criminal activity that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing in the immediate vicinity of the premises (see CFR 982.553).
22. Alcohol abuse by household members. The members of the household must not abuse alcohol in a way that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing in the immediate vicinity of the premises.
23. Other housing assistance. An assisted family, or members of the family, may not receive SPC tenant-based assistance while receiving any other housing subsidy, for the same unit or for a different unit, under any duplicative (as determined by HUD or in accordance with HUD requirements) federal, State or local housing assistance program.

I have read the above and understand that my assistance can be cancelled for these reasons.

Name of Head of Household (Print)

Signature of Head of Household

Date

GROUNDNS FOR DENIAL OR TERMINATION BY HOUSING AUTHORITY

The Housing Authority may, at any time, deny program assistance for an applicant, or terminate program assistance for a participant, for any of the following reasons:

- If the family violates any family obligation under the SPC program;
- If any member of the family has been evicted from public housing;
- If a Housing Authority has ever terminated assistance under the certificate or voucher program for any member of the family;
- If any member of the family commits drug-related or criminal activity;
- If any member of the family commits fraud, bribery or any other corrupt or criminal act in connection with any federal housing program;
- If the family currently owes rent or other amounts to the Housing Authority or to another Housing Authority in connection with Section 8 or other public housing assistance under the 1937 Act;
- If the family has not reimbursed any Housing Authority for amounts paid to an owner under a HAP contract for rent, damages to the unit, or other amounts owed by the family under the lease;
- If the family breaches an agreement with the Housing Authority to pay amounts owed to a Housing Authority, or other amounts to the owner paid by a Housing Authority. The Housing Authority, at its discretion, may offer a family the opportunity to enter into an agreement to pay amounts owed to a Housing Authority or amounts paid to an owner by a Housing Authority (the Housing Authority may prescribe the terms of the agreement);
- If the family has engaged in or threatened abusive or violent behavior toward Housing Authority personnel;
- The family's action or failure to act;

I have read the above and understand that my assistance can be cancelled for these reasons.

Name of Head of household (Print)

Signature of Head of household

Date

COUNTY OF FRESNO AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Case Name _____
Case Number _____
Worker Name _____
Worker Number _____
Worker Telephone _____
Date _____

I authorize the staff of the Fresno Housing Authorities and the Fresno County Department of Social Services to discuss eligibility factors and provide the following information relating to my CAL WORKS case(s).

I understand that all information is confidential, and that no information will be released to any other person outside of these two agencies without my consent.

I understand that I can revoke this authorization at any time.

I certify that I have read (or had read to me) and understand the contents of this form.

I understand and agree that a photocopy of this form and my signature shall be considered as valid as the original.

Signature: _____ Date _____

CSF 15 (replaces ES0075 and ES0075A)

CONSENT FOR RELEASE OF INFORMATION

Include the following documents in your packet – Documents cannot be older than 60 days.

Income Type	What you need to include with your packet:
Adding Household members/Multiple Subsidies	If you are claiming someone who is receiving subsidy in another household, documentation must be provided verifying that they will be residing in your household.
Cash/Gifts and/or Contributions	You must provide a notarized statement detailing the source and amount of cash/gifts received monthly. For gifts, you must supply a dollar amount.
Checking and/or Savings Account	Statements from the last two (2) months from any bank, financial institution where any family member has an account.
Child Care	A letter from the public agency or private entity certifying that the family pays for Child Care Expenses. The letter must indicate the names of the children being cared for; the total number of hours they are cared for per week/month, and the total cost per week/month whether for work or school.
Child Support	A quarterly printout from the Family Support Division, or court-awarded documents showing the amount being paid for child support.
Disability Certification	If any family member is identified as disabled, please provide the name of the certifying professional, mailing address and phone number.
Employment or Seasonal Employment	Provide copies of your check stubs for the most current two (2) months of employment, along with your W-2, complete tax form, and/or employment printout.
Foster Care/Adoption Assistance Payments	A current WHIS report from the Department of Social Services.
General Relief	Please provide a current notice of action from the Human Services System.
Job Training	Letter from public agency or trade school certifying participation in a job training program.
Medical Expenses	Receipts from your physician, medical insurance company or pharmacy providing the proper verification for out-of-pocket medical expenses you anticipate for the next 12 months.
Other Assets	Provide the value of the asset and/or statement of maturity of the asset.
Self-Employment	A copy of your business account for the past twelve (12) months or profit/loss statement, Schedule C and all pages of your signed Income Tax Return from the previous year.
Social Security SSA/SSI	A current printout or award letter from the Social Security Department. You can obtain one by calling the Social Security Office at (800) 772-1213. We cannot accept photocopies of your checks. If benefits are reduced due to monies overpaid to you, we will need to know the amount you owe the agency and the reason the overpayment occurred.
Student Verification	All students applying separately from their parents who are under the age of 24, not married, not a veteran, and do not have dependents must attach the "Student Verification Information Sheet." The form can be obtained by picking it up from our office at 1331 Fulton Mall, or downloading from our website: www.hafresno.org . Homepage-Popular Documents - Click on "View all available forms" Scroll down to Housing Choice Voucher Tenant (Section 8)-Student Verification Form. Complete the form, attach to this packet and bring with you.
Student/Financial Aid	Adult students must attach verification of full-time & part-time student status, all financial aid amounts and all scholarship amounts received.
TANF	A current WHIS report from the Department of Social Services, or contact your worker. If benefits are reduced we will need to know the reason.
Unemployment/State Disability.	Provide a copy of your award letter from the Employment Development Department (EDD) office for any benefits being received, or which have been received within the past twelve (12) months for any family member. If you have been denied unemployment benefits, you must provide a copy of the denial letter. You can obtain one by calling the EDD office at (800) 300-5616 or (800) 326-8937.

HMIS DATA COLLECTION TEMPLATE: PROJECT START DATE

Form for all Project Types

Use block letters for text and bubble in the appropriate circles. Please complete a separate form for each household member.

PROJECT START DATE [All Clients]

		-			-				
--	--	---	--	--	---	--	--	--	--

Month Day Year

Project Name:	
Date of data collection:	
Time of data collection:	
Collected by:	

SOCIAL SECURITY NUMBER [All Clients]

			-			-			
--	--	--	---	--	--	---	--	--	--

QUALITY OF SOCIAL SECURITY			
	Full SSN reported		Client doesn't know
	Approximate or partial SSN reported		Client refused

NAME [All Clients]	
First	
Middle	
Last	
Suffix	
Alias	

QUALITY OF NAME	
	Full name reported
	Partial, street name, or code name reported
	Client doesn't know
	Client refused

DATE OF BIRTH [All Clients]

		-			-				
--	--	---	--	--	---	--	--	--	--

Month Day Year

VETERAN STATUS [All Adults]	
	No
	Yes
	Client doesn't know
	Client refused

QUALITY OF DATE OF BIRTH			
	Full DOB reported		Client doesn't know
	Approximate or partial DOB reported		Client refused

RELATIONSHIP TO HEAD OF HOUSEHOLD [All Clients]	
	Self
	Head of household's child
	Head of household's spouse or partner
	Head of household - other relation to member
	Other: non-relation member

GENDER [All Clients]			
	Female		Gender Non-Conforming (i.e. not exclusively male or female)
	Male		Client doesn't know
	Trans Female (MTF or Male to Female)		Client refused
	Trans Male (FMT or Female to Male)		

RACE [All Clients]			
	American Indian or Alaska Native		Client doesn't know
	Asian		Client refused
	Black/African American		
	Hawaiian or Other Pacific Islander		
	White		

ETHNICITY [All Clients]			
	Non-Hispanic		Client doesn't know
	Hispanic/Latino		Client refused

CURRENT LIVING SITUATION [Head of Household and Adults]			
	Place not meant for human habitation (e.g., a vehicle, an abandoned building bus/train/subway station/airport or anywhere outside)		Staying or living in a family member's room, apartment or house
	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter		Rental by client, with GPD TIP housing subsidy
	Safe Haven		Rental by client, with VASH housing subsidy
	Foster care home or foster care group home		Permanent housing (other than RRH) for formerly homeless persons
	Hospital or other residential non-psychiatric medical facility		Rental by client, with RRH or equivalent subsidy
	Jail, prison or juvenile detention facility		Rental by client, with HCV voucher (tenant or project based)
	Long-term care facility or nursing home		Rental by client in a public housing unit
	Psychiatric hospital or other psychiatric facility		Rental by client, no ongoing housing subsidy
	Substance abuse treatment facility or detox center		Rental by client, with other ongoing housing subsidy
	Residential project or halfway house with no homeless criteria		Owned by client, with ongoing housing subsidy
	Hotel or motel paid for without emergency shelter voucher		Owned by client, no ongoing housing subsidy
	Transitional housing for homeless persons (including homeless youth)		Client doesn't know
	Host Home (non-crisis)		Client refused
	Staying or living in a friend's room, apartment, or house		

LENGTH OF STAY IN PRIOR LIVING SITUATION			
	One night or less		One month or more, but less than 90 days
	Two to six nights		90 days or more, but less than one year
	One week or more, but less than one month		One year or longer
			Client doesn't know
			Client refused

If client is immediately coming from a TH/PH living situation, did they stay less than 7 nights?

	No
	Yes

If client is immediately coming from an INSTITUTIONAL living situation did they stay less than 90 days?

	No
	Yes

On the night before the TH/PH OR INSTITUTIONAL living situation, did client stay on the streets, emergency shelter, or Safe Haven?

	No
	Yes

APPROXIMATE DATE HOMELESSNESS STARTED

Date:

NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, ES, OR SAFE HAVEN IN THE LAST 3 YEARS

	One time		Client doesn't know
	Two times		Client refused
	Three times		
	Four or more times		

NUMBER OF MONTHS THE CLIENT HAS BEEN ON THE STREETS, ES, OR SAFE HAVEN IN THE LAST 3 YEARS

	One month (this is the first time)		Client doesn't know
	2 - 12 months (specify number of months):		Client refused
	More than 12 months		

DISABLING CONDITION [All Clients]

	No		Client doesn't know
	Yes		Client refused

Physical Disability [All Clients]			
	No		Client Doesn't Know
	Yes		Client Refused
If "Yes" to Physical Disability - Specify			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	No		Client Doesn't Know
	Yes		Client Refused

Developmental Disability [All Clients]			
	No		Client Doesn't Know
	Yes		Client Refused

Chronic Health Condition [All Clients]			
	No		Client Doesn't Know
	Yes		Client Refused
If "Yes" to Chronic Health Condition - Specify			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	No		Client Doesn't Know
	Yes		Client Refused

HIV/AIDS [All Clients]			
	No		Client Doesn't Know
	Yes		Client Refused

Mental Health Problem [All Clients]			
	No		Client Doesn't Know
	Yes		Client Refused
If "Yes" to Mental Health Problem - Specify			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	No		Client Doesn't Know
	Yes		Client Refused

Substance Abuse Problem [All Clients]			
	No		Both alcohol and drug abuse
	Alcohol abuse		Client Doesn't Know
	Drug abuse		Client Refused
If "Yes" to Substance Abuse Problem - Specify			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	No		Client Doesn't Know
	Yes		Client Refused

INCOME FROM ANY SOURCE [Head of Household and Adults]			
---	--	--	--

No		Client Doesn't Know		
Yes		Client Refused		
If "Yes" to Income From Any Source - Indicate ALL sources that apply (Round to the nearest dollar)				
Income Source		Amount	Income Source	Amount
Earned Income			Temporary Assistance for Needy Families (TANF)	
Unemployment Insurance			General Assistance (GA)	
Supplemental Security Income (SSI)			Retirement Income from Social Security	
Social Security Disability Insurance (SSDI)			Pension or Retirement Income from a Former Job	
VA Service-Connected Disability Compensation			Child Support	
VA Non-Service-Connected Disability Pension			Alimony and Other Spousal	
Private Disability Compensation			Other Source	
Worker's Compensation				
Total Monthly Income for Individual:				

RECEIVING NON-CASH BENEFITS [Head of Household and Adults]			
No		Client Doesn't Know	
Yes		Client Refused	
If "Yes" to Non-Cash Benefits - Indicate ALL sources that apply			
Non-Cash Benefits			
Supplemental Nutrition Assistance Program (SNAP)			
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)			
TANF Childcare Services			
TANF Transportation Services			
Other TANF-funded services			
Other (Specify):			

COVERED BY HEALTH INSURANCE [All Clients]			
No		Client Doesn't Know	
Yes		Client Refused	
If "Yes" to Health Insurance - Health Insurance Coverage Details			
MEDICAID			Health Insurance Obtained Through COBRA
MEDICARE			Private Pay Health Insurance
State Children's Health Insurance (SCHIP)			State Health Insurance for Adults
Veteran's Administration (VA) Medical Services			Indian Health Services Program
Other (Specify):			

DOMESTIC VIOLENCE VICTIM/SURVIVOR [Head of Household and Adults]			
	No		Client Doesn't Know
	Yes		Client Refused
If "Yes" to Domestic Violence			
When Experience Occurred			
	Within the past three months		Client Doesn't Know
	Three to six months ago (excluding six months exactly)		Client Refused
	Six months to one year ago (excluding one year exactly)		
	One year ago or more		

Fresno Madera Continuum of Care
Client Informed Consent & Release of Information Authorization
Homeless Management Information System (HMIS)

Fresno Housing is a Partner Agency in the Homeless Management Information System (HMIS). HMIS is a shared homeless and housing database system administered by The Fresno Housing Authority (FH). HMIS can improve the services and programs for homeless and low income households by allowing authorized staff at Partner Agencies to share client information and to follow trends and service patterns over time. HMIS operates over the internet and uses many security protections to ensure confidentiality. This Agency will collect your information and enter it into HMIS.

Participation in the HMIS program is important to our community's ability to provide you with the best services and housing possible. As you receive services, Basic Information and Coordination of Care and Housing Information (listed below) will be collected about you, the services provided to you, and the outcomes these services help you to achieve.

A representative of this Agency is going to ask you for information about you and your dependents. The word "dependent" is used in this documents to refer to any person under the age or 18 for whom you consider yourself to be responsible for. Once your information is entered into HMIS it will be shared as described below.

Basic Information:

This information will be shared through HMIS and partner agencies utilizing HMIS.

- Personal Identifying Information (Name, Social Security Number, Date of Birth, Gender, Race, Ethnicity, Veteran Status, and photo)
- Household information
- Personal Identifying Information about your dependents (if applicable)
- Enrollment information

Coordination of Care and Housing Information:

This information, along with other information from the HMIS will be used or disclosed for the purposes of matching you to the appropriate services and possible housing, to conduct referrals and assessments, to determine program eligibility, to otherwise collaborate to address specific needs and circumstances, and to share information in case conference meetings for the purposes of finding and/or coordinating services for you and your dependents.

- Contact Information
- Experience with homelessness and living situation
- Household income and source(s)
- Presence of a current disabling condition
- Services you receive
- Documents to support homeless situation, income, disabling condition, and identity for the purpose of housing match

As stated in our Notice of Privacy Policy, we are required by law to maintain the privacy of this information and explain how, when and why we may use or disclose any of this information.

- Your name and other identifying information will not be shared with any agency not participating in the system (unless required to do so by law).

- Your name, gender, race, social security number and date of birth and other Basic Information may be shared with Partner Agencies for Identification purposes even if you elect not to share other sensitive information.
- Sensitive information, such as diagnosis or treatment or mental health disorders, drug or alcohol disorders, HIV/AIDS, or domestic violence concerns, **will not** be shared between Partner Agencies without specific written consent.
- A list of Partner Agencies is available upon request.
- **Authorizing your information to be entered into the HMIS is voluntary.**
- **Refusing to do so will not limit your access to shelter or services.**

Please initial ONE of the following levels of consent:

____ (1) I give authorizations for my basic and coordination of care and housing information to be entered into the HMIS and shared between Partner Agencies. I understand that I have the right to receive a copy of all information shared between the Partner Agencies.

____ (2) I give authorization for my basic and relevant information to be entered into the HMIS, but **not shared** between Partner Agencies. My information will not be shared, used or disclosed at case conference meetings and may make it more difficult for participating agencies to qualify me for assistance suited to my needs.

I understand that I may cancel this authorization at any time by written request, but the cancellation will not be retroactive. I understand that I have the right to view my HMIS record and will have a report prepared within 72 business hours of my written request. I understand that if I refuse consent to share this information I cannot be denied services. I understand that this release is valid for ____ years from the date of my signature.

Name and Date of Birth of dependents (under 18 only)

NAME	Date of Birth

Client Name (please print)

Client Signature Date

Agency Staff Name (please print)

Agency Staff Signature Date

Fresno Madera Continuum of Care

HMIS Partner Agencies

Effective April 2020

Community Action Agency Partnership of Madera

Fresno EOC Sanctuary and Support Services

Fresno Housing Authority

Fresno Madera Coordinated Entry Agency Partners*

Kings View

Madera County Department of Behavioral Health Services

Mental Health Systems

Poverello House

RH Community Builders

Selma Community Outreach Ministries

Turning Point

Valley Teen Ranch

Veteran Administration

WestCare California

*Fresno Madera Coordinated Entry Agency Partners include:

Centro La Familia

Clinica Sierra Vista

Fresno County Department of Behavioral Health

Shelter Plus Care Program (SPC) Participant-Service Provider Agreement

The purpose of this agreement is to document the commitment of the supportive services agency for providing services to the SPC Program participant, and to clearly outline the roles and responsibilities of the participant and service provider in regards to service provision for SPC program compliance.

Name of the Service Provider: _____

Name of the Case Manager: _____

Phone Number of the Case Manager: _____ Fax Number: _____

Name of the Participant: _____

By signing the document, the Service Provider agrees to:

- Act as the primary service provider for the above-named participant.
- Assign a case manager to work with the participant and to be the main contact person for the Housing Authority of the City of Fresno (Housing Authority).
- Assist the participant to develop an Individual Service Plan designed to help maintain housing stability, and meet the participant's self-directed goals.
- Assist the participant to access services he/she has identified in the Individual Service Plan.
- Provide documentation of the services provided to the participant. Communicate promptly with the Housing Authority, regarding any concerns about the participant's housing stability.
- Provide the participant and Housing Authority with a 180-day notice of intent to terminate this agreement.
- Provide the Housing Authority with the required cash match in supportive services for the SPC participant

By signing this document, the Participant agrees to:

- Maintain regular contact with the identified Case Manager.
- Meet with the Case Manager at least once per month (or less if mutually agreed with case manager).
- Work with the case manager to achieve the goals in the Individual Service Plan.
- Communicate promptly with Housing Authority regarding any concerns with regard to the supportive services received.
- Provide the Service Provider and Housing Authority with 60-day notice of intent to terminate this agreement.
- Authorize the staff of the Housing Authority and the Supportive Service agency to share information relating to SPC rental assistance and supportive services required for SPC program participation.
- Inform Service Provider if receiving supportive services from other service agencies.

Authorized Service Provider Representative	Date
Participant's Signature	Date
Housing Authority Staff	Date



**SHELTER PLUS CARE PROGRAM (SPC)
AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL INFORMATION**

Participant Name _____
SPC Certificate Number _____
Service Provider Name _____
Service Provider Staff _____
Date _____

I authorize the staff of Housing Authorities City and County of Fresno and personnel of the following agencies below to share information relating to my SPC housing and supportive services.

- | | |
|---|---|
| <input type="checkbox"/> Angels of Grace | <input type="checkbox"/> Spirit of Women |
| <input type="checkbox"/> Resources for Independence Central Valley | <input type="checkbox"/> Fresno Unified School District- Project Access |
| <input type="checkbox"/> Central Valley Regional Center | <input type="checkbox"/> Catholic Charities |
| <input type="checkbox"/> Department of Behavioral Health | <input type="checkbox"/> Opportunity Assistance & Socially Integrated Services |
| <input type="checkbox"/> County of Fresno Employment & Temporary Assistance | <input type="checkbox"/> Department of Public Health |
| <input type="checkbox"/> Fresno Interdenominational Refugee Ministries | <input type="checkbox"/> Department of Veterans Affairs |
| <input type="checkbox"/> West Care/The Living Room | <input type="checkbox"/> Fresno Unified School District- Lowell Elementary School |
| <input type="checkbox"/> Fresno County Economic Opportunities Commission | <input type="checkbox"/> Kings View |
| <input type="checkbox"/> CMC Specialty Health Center | <input type="checkbox"/> Marjaree Mason Center |
| <input type="checkbox"/> Samaritan Woman | <input type="checkbox"/> Department of Children and Family Services |
| <input type="checkbox"/> Poverello House | <input type="checkbox"/> Fresno Rescue Mission |
| <input type="checkbox"/> Alternative Vocational Services Employment | <input type="checkbox"/> CMC Community Connections |
| <input type="checkbox"/> Fresno Center for New Americans | <input type="checkbox"/> Turning Point |
| | <input type="checkbox"/> Other _____ |

I understand that all information is confidential, and that no information will be released to any other person outside of these agencies without my consent.

I understand that I can revoke this authorization at any time by providing the Housing Authorities City and County of Fresno with written notification.

I certify that I have read (or had read to me) and understand the contents of this form.

I understand and agree that a photocopy of this form and my signature shall be considered as valid as the original. This document is valid for two years.

Participant Signature: _____

Date: _____

If you are a person with disabilities and require reasonable accommodation, you must submit your request in writing or call Andrea Garcia at 559 457-4264. The Housing Authority will make all reasonable efforts in assisting persons with disabilities. Examples of reasonable accommodations include: Home Visits, TDD or TDY access and/or use of an interpreter.



SELF-DEALING TRANSACTION DISCLOSURE FORM

In order to conduct business with the County of Fresno (hereinafter referred to as "COUNTY"), members of a CONTRACTOR's board of directors (hereinafter referred to as "County Contractor"), must disclose any self-dealing transactions that they are a party to while providing goods, performing services, or both for the COUNTY. A self-dealing transaction is defined below:

"A self-dealing transaction means a transaction to which the corporation is a party and in which one or more of its directors has a material financial interest"

The definition above will be utilized for purposes of completing this disclosure form.

INSTRUCTIONS

- (1) Enter board member's name, job title (if applicable), and date this disclosure is being made.
- (2) Enter the board member's company/agency name and address.
- (3) Describe in detail the nature of the self-dealing transaction that is being disclosed to the COUNTY. At a minimum, include a description of the following:
 - a. The name of the agency/company with which the corporation has the transaction; and
 - b. The nature of the material financial interest in the corporation's transaction that the board member has.
- (4) Describe in detail why the self-dealing transaction is appropriate based on applicable provisions of the Corporations Code.
- (5) Form must be signed by the board member that is involved in the self-dealing transaction described in Sections (3) and (4).

(1) Company Board Member Information:			
Name:		Date:	
Job Title:			
(2) Company/Agency Name and Address:			
(3) Disclosure (Please describe the nature of the self-dealing transaction you are a party to):			
(4) Explain why this self-dealing transaction is consistent with the requirements of Corporations Code 5233 (a):			
(5) Authorized Signature			
Signature:		Date:	