Dedicated to the Health
Of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Mental Health Department
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MHSA HOUSING AVAILABILITY ANNOUNCEMENT

March 1, 2011

Interested and qualified seniors (age 62 and above) are encouraged to apply for the sixteen (16) Mental Health Service Act-designated one-bedroom apartments and two (2) two-bedroom apartments at Fair Oaks Plaza, located at 660 South Fair Oaks Avenue, Sunnyvale, CA 94086, two blocks north of El Camino Real. This project provides a community meeting room with kitchen, laundry, access to computers, public restrooms, an outdoor picnic/BBQ area, emergency call alert system (available for a fee), and a gated, covered parking garage. The project is also located within ¼ mile of the Sunnyvale Community Center and Braly Park.

MHSA Rent and Utility Amounts

The monthly rent that the tenant pays is 30% of his or her income. The tenant is responsible for paying for their electricity. The owner will pay for water, sewer and trash. The tenant will also be responsible for phone and cable service if they choose to subscribe.

AGE RESTRICTION

This development is reserved for Senior Citizens which is defined as 62 years and above. All members of the household must meet the age restriction of 62 years and above.

MHSA Tenant Qualifying Criteria

Qualified tenants must meet the requirements stated in 1-4 below.

1. Individuals must be:
   a) "Seriously mentally ill":
      - Low income older adults with serious mental illness as defined in *California Welfare and Institutions Code* 5600.3(b)(1); and
      - Who, at the time of assessment for housing services, meet the criteria for MHSA services in their county of residence.
   b) "Homeless," which means living on the streets, or lacking a fixed, regular, and adequate nighttime residence. (This includes shelters, motels and living situations in which the individual has no tenant rights.)
   c) OR "at risk of homelessness," which includes:
      - Individuals discharged from institutional settings including:
        - Hospitals, including acute psychiatric hospitals, psychiatric health facilities (PHF), skilled nursing facilities (SNF) with a certified special treatment program for the mentally disordered (STP), and mental health rehabilitation centers (MHRC)
        - Crisis and transitional residential settings

- Individuals released from local city or county jails
- Individuals temporarily placed in residential care facilities upon discharge from one of the institutional settings cited above
- Individuals who have been assessed and are receiving services at the county mental health department and who have been deemed to be at imminent risk of homelessness, as certified by the county mental health director.

2. Individuals must be older adults (62 years and above).
3. Individuals must have an annual household income below $22,300 (1 person), $25,500 (2 persons), $28,650 (3 persons). This is 30% of the current Area Median Income for a given household size.
4. Individuals must meet one of the following two Santa Clara County requirements:
   a) Be "mid-level users" of services at clinics/contract agencies; that is seriously mentally ill clients who do not currently need 24-hour, institutional care but are unable to live independently without supportive services. These are consumers who are homeless or at risk of homelessness (according to MHSA Housing Program Application) and who:
      - use outpatient services and are usually dependent on such;
      - are able, with support, to manage their Activities of Daily Living and medications in an independent living situation; and
      - have severely limited income or are assumed to have a continuing income deficiency for the next 12 months;

      (This includes new consumers who have previously been unserved.)
   b) Have left a 24-hour care setting and have demonstrated success or have completed their stay in a transitional or residential care facility and can move to permanent supportive housing as a next step in their recovery.

Note: Staff at the clinic or contract agency will help to determine which consumers fulfill these criteria and refer the candidate to MHD.

To Apply.

1. Interested and qualified seniors wishing to apply are asked to submit the attached MHSA Housing Program Eligibility form and the Consent to Release Confidential Health Information form by **April 27, 2011** to:

   Robert A. Dolci, M.A.
   Homeless Concerns Coordinator
   Santa Clara County Mental Health Department
   650 South Bascom Avenue, Suite A
   San José, CA 95128

   The above-referenced forms can be either delivered or mailed to the above address or they can be emailed to Mr. Dolci at: robert.dolci@hhs.sccgov.org.

2. All interested seniors age 62 and above wishing to apply for an MHSA designated unit or any other unit must also fill out an application **by May 4, 2011** for a unit at the following address:

   915 West El Camino Real
   Sunnyvale, CA 94087

   The above-referenced forms should be delivered to the above address in person.

Questions

For additional information, call Mr. Dolci at (408) 793-6451 or Ms. Kathy Bogges at (408) 333-9811.

MHD Staff Use Only:	
Date Received _____	Tenant's Unicare #: _____
Date Approved/Denied _____	Tenant's Telephone # _____

Santa Clara County Mental Health Department
MHSA HOUSING PROGRAM
Eligibility Form

NAME: Last _____ **First** _____

Date of Birth _____ **Social Security #** _____

Service Provider _____ **Provider RU#** _____

Case Manager _____ **Phone #:** _____

Age Grouping: ☐ 0-15 ☐ 16-25 ☐ 26-59 ☐ 60+

Ethnicity:

☐ African American
☐ African Immigrant
☐ American Indian/Alaskan Native
☐ Caucasian
☐ Persian/Iranian
☐ Russian
☐ Chinese
☐ Filipino
☐ Vietnamese
☐ Asian Indian
☐ Cambodian
☐ Other Asian/Pacific Islander
☐ Mexican/Mexican American
☐ Other Latino
☐ Eastern European
☐ Other: _____

Are you:
☐ Homeless?
☐ At risk of being homeless?

Do you have a:
☐ Physical disability?
☐ Health condition that warrants special accommodation?

Treatment Language Preference:
☐ English ☐ Spanish ☐ Vietnamese ☐ Tagalog ☐ Chinese ☐ Other:_____

What is your primary source of income?
☐ Work ☐ General Assistance ☐ Unemployment ☐ SSI ☐ SSDI ☐ SSA
Other _____

Gross monthly income _____ Annual income _____

Do you have rep payee services? Yes No Are you conserved? Yes No

Where are you living now? _____

Current mailing address_____

_____

Have you ever been evicted from housing? Yes No

Comment: _____

Who is your primary source of support? _____

That person's phone # is: _____

I verify that the information provided is true and I understand that if I have falsified information, I will be ineligible for the MHSA Housing Program.

Signature _____ Date _____
Prospective Tenant

Signature _____ Date _____
Service Provider Staff

The information regarding race, national origin, and sex designation solicited on this application is requested in order to assure the Federal Government that Federal Laws prohibiting discrimination against tenant applicants on the basis of race, color, national origin, religion, sex, familial status, age, and handicap are complied with. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, the owner is required to note the race/national origin and sex of individual applicants on the basis of visual observation or surname.

CONSENT TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Client's Name:	DOB:

I, *(Name of Client)* _____ and / or

(Parent/Legal Guardian/Conservator) _____ authorize

(Releasing Agency) _____ to disclose to

(Receiving Agency/Person) _____ *(Address)* _____

the following information with the knowledge such release discloses the fact that the named person has received mental health services.

The disclosure shall be limited to the following specific information *(Nature and amount of information to be disclosed; as limited as possible to accomplish the stated purpose or intended use):*

____ Diagnosis
____ Summary of psychological and psychiatric history
____ Medical information including the results of medical tests
____ Other: _____

___ Results of psychological and vocational tests
___ Legal Status
___ Educational assessment and behavioral reports (including school observation and educational testing)

This disclosure of the above-mentioned specific mental health information is required for evaluation, treatment or for the following purpose (indicate as specific as possible, the purpose and use of the disclosure):

_____

I understand that: 1)My mental health records are protected under the California Welfare and Institutions Code (WIC) and the federal Health Insurance Portability and Accountability Act (HIPPA) of 1996, and cannot be disclosed without my written consent unless otherwise provide for by the regulations. The exceptions are set forth in the *Notice of Privacy Practices*; 2) I may revoke my consent by providing a written notice withdrawing my consent; and 3) If the program has already disclosed information in reliance on my consent, the program is not required to try to retrieve that information.

If not earlier revoked, this consent shall automatically terminate and expire on or as follows *(Specify the date, event or condition, upon which this consent expires):* _____

Client's Signature _____ Date _____

Parent/Legal Guardian/Conservator's Signature _____ Date _____

I certify that I have reviewed with the client or with his/her representative this Consent to release Confidential Health Information:

☐ I find that the client has the capacity to give informed consent or the client's representative has the legal authority to act for the client. I hereby authorize the release of the requested information.

☐ I find that the client does not have the capacity to give informed consent or the client's representative does not have or is not clear if he/she has the legal authority to act for the client. I hereby do not authorize the release of the requested information.

Signature of Authorized Staff _____ Date _____