Emergency Housing Assistance Request Form

Submit request to:
Contra Costa Health Department
597 Center Avenue, Suite 200
Martinez, CA 94553
Telephone: (925) 313-6771
Fax: (925) 313-6798

**ATTACH LEASE**

Date_________ Housing Advocate__________________ Case Manager__________________
Client Name__________________ CARE ID___________ Monthly Income__________________
Names/ages others in family________________________________________________________
New Address: _____________________________________________________________________
Request (Circle): rent   first/last rent   deposit   subsidy   motel   other_______________________
Amount $_________Amount$_________Amount$_________ Total$____________________
When Needed_____________ Monthly rental cost (including utilities) $___________________
Subsidy Duration_________ Taxpayer ID______________________________________________
Landlord name /Address _____________________________________________________________________

Address to send check to if different from above: _____________________________________________________________________
Hold check for pickup?  Y  N

Housing resources checked__________________________________________________________
Quick check:
Income update________ FPL________ Resident_____ Previous HA access?  Y  N (when______)
History drug/alcohol abuse?  Y  N     Money management needed?  Y  N     Eviction notice?  Y  N
Client statement______ Certification of Need______ Housing Plan_________ Compliancy? Y  N

Office use only: ARIES check:
Financial__ Demographic__ Insurance__ MD Visit_____ Services_____ S/NS_____ Case Notes_____
Pending___________________________________________________________
Authorized__________________________________________________________
Cost Center________ Other___________________________________________

**CSGA PROTOCOL**

Referral Forms