



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 _____ Date _____

Cost Center _____ Other _____