Exhibit E
Annual Self-Certification Form

CALIFORNIA HOUSING FINANCE AGENCY (CalHFA)
Mental Health Services Act (MHSA) Housing Program
Annual Self-Certification for Special Needs

County: _____
Project Name: _____
MHSA Loan # _____
Cert. of Occupancy or Notice of Completion Date _____

Self Certification Report Period from: _____ to _____

Contact Information:

Project Sponsor		Phone:
Primary Service Provider		Phone:

1. Changes During Report Period:

Please check applicable items. For each checked item, please attach all letters, notes, correspondence and/or written notices documenting the change.

- ☐ New sources of service funds
- ☐ Service funding increases or decreases
- ☐ New service partners
- ☐ Service partner cancellation
- ☐ Service program enhancements or reductions
- ☐ Other planned service program modifications
- ☐ Primary service provider staffing changes
- ☐ Service funding source cancellation
- ☐ Non-renewal of service funding sources
- ☐ Non-compliance with other lenders' Regulatory Agreements
- ☐ Non-compliance with rental subsidy contracts
- ☐ Non-compliance with services contracts
- ☐ Extension of rental subsidy contracts
- ☐ Termination of rental subsidy contracts

2. Subsidy Sources:

Total number of units with rental subsidy contracts: _____

Years remaining on current rental subsidy contracts (please list):

Type of Subsidy	Number of Units	Years Remaining

3. Current Resident Information

Total number of units in project	
Total number of MHSA Housing Program target units in project	
Total number of MHSA eligible residents in project	
Total number of persons residing in MHSA eligible units	
Total number of MHSA housing units receiving COSR	
Total number of MHSA units with an individual Section 8 voucher	
Total number of MHSA units with a project based Section 8 voucher	
Total Number of MHSA eligible residents receiving SSI	

4. During this Report Period: MHSA Eligible Residents Who Have Left the Housing

(Show the number of permanent **(P)** and temporary **(T**) departures

T

P	T	Reason for Leaving	P	T	Reason for Leaving
		Hospitalization			Death
		Moved to a licensed facility			Other
		Moved to more independent housing			
		Eviction			
		Jailed			

Total number of temporary departures _____

Total number of permanent departures _____

Provide the following for each MHSA eligible resident who permanently departed from an MHSA unit: 1) Length of residency, 2) Income level at termination of tenancy.

Explanation(s):

5. During this Report Period: MHSA Resident Demographics

Enter the number of MHSA eligible residents in each category (may be duplicated)

☐	Living alone	☐	Chronic health condition
☐	Living with other(s)	☐	HIV/AIDS
	☐ Children ☐ Spouse ☐ Unrelated persons	☐	Substance Abuse
		☐	Other serious medical condition

6. During this Report Period: Housing status at rent-up

Total Homeless: _____

Total At risk: _____

7. Total MHSA Priority Populations in project:

Older Adults: _____

Adults: _____

Transition age youth: _____

Children: _____

Total MHSA eligible residents enrolled in Full Service Partnership (FSP) services: _____

Total number of MHSA eligible residents who are veterans _____

Total number of tenants who are veterans _____

8. Service Providers (please attach additional pages if needed)

Please list requested information for all service providers, whether individuals or organizations/institutions, and whether the service provider provides services on site or off site:

Provider Name	Address	Phone Number	Contact Person	On-Site	Off-Site
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

9. Supportive Services---Resources and Utilization

Indicate the services that have been offered to the MHSA eligible residents in this project during the reporting period. Also, indicate if these services are offered on-site or off-site, and the frequency of the service (times per week, per month, as needed, etc.):

Service Type	On-site	Off-site	Frequency
Service coordination	☐	☐	
Case management/crisis intervention	☐	☐	
Mental health services	☐	☐	
Substance abuse services	☐	☐	
Peer facilitated groups/activities	☐	☐	
Medication education/support	☐	☐	
Life skills	☐	☐	
Employment/vocational services	☐	☐	
Tenant association/council	☐	☐	

Benefits counseling	☐	☐	
Social/recreational activities	☐	☐	
AA/NA groups	☐	☐	
Primary care: Health screening, assessment, education	☐	☐	
Other:	☐	☐	

Provide a narrative description of the strengths and challenges in the supportive services program during this reporting period:

10. Supportive Service Budget Information

Please provide budget information for your previous and current fiscal years, including costs of staff and services combined:

Previous year budgeted funding level (FY:)	$
Previous year actual funding level (FY:)	$
Current year budgeted funding level (FY:)	$

11. Property and Liability Insurance

Current Insurance Certificates on file	Yes ☐ No ☐

12. Executed Management Contract

Executed Management Contract on file	Yes ☐ No ☐

CalHFA must approve any change in management agent so please notify your Asset Manager of an impending change.

13. Inspection Reports

Has property been inspected by any lender during the reporting period?	Yes ☐ No ☐

If inspected by a party other than CalHFA, please forward a copy of the report(s) to your CalHFA Asset Manager.

Certification of Accuracy of Information Provided

I hereby certify that the information provided in this "Annual Self-Certification for Special Needs" is true and correct, and reflects the status of the _____ project as of the date of this report.

Signed by: _____ Date: _____

Title: _____

Organization: _____

Certification that a copy of this report has been sent to CalHFA, the Department of Health Care Services and the County Mental Health Department at the addresses listed below.

Signed by: _____ Date: _____

Title: _____

Organization: _____

Mailing Addresses:

California Housing Finance Agency
Asset Management Division
500 Capitol Mall, Suite 1400
Sacramento, CA 95814

Department of Health Care Services
Mental Health Services Division
Program Outcomes, Evaluation and Reporting
1500 Capitol Avenue, MS 2704
PO Box 997413
Sacramento, CA 95814

_____**County Mental Health Department**
Contact Name: _____
Street:_____
City/State/Zip:_____