Exhibit E
Annual Self-Certification Form

CALIFORNIA HOUSING FINANCE AGENCY (CalHFA)

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)

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 certified residents in project ________
Total number of persons residing in MHSA Housing Program units (to include MHSA ________
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)

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

Reason for Leaving	P	T
Death		

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	_______	Substance Abuse
_______	Spouse	_______	Other serious medical condition
_______	Unrelated persons		

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	☐	☐	
	☐	☐	

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:	$
Approved by County Department of Mental Health and submitted to the DHCS		Yes ☐ No ☐

Please submit current FY budget /narratives to the DHCS mailing address below.

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.

14. Capital Operating Subsidy Reserve (COSR) Certification

Amount of COSR requested during Fiscal Year:	$
Actual COSR used during Fiscal Year:	$
Difference:	$

If COSR requested amount is greater than what was used during the Fiscal Year, the difference will be subtracted from the next COSR request.

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, DHCS, 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 - MS
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 95899-7413

______________________________ **County Mental Health Department**

Contact Name: ______________________________
Street Address: ______________________________
City: ______________________________
State: ______________________________
Zip Code: ______________________________