Los Angeles HOMELESS SERVICES AUTHORITY
Working Together to End Homelessness in Los Angeles

INTERIM HOUSING
90-DAY EXTENSION FORM

This Form should be used for documenting the extension of stay for a participant or household within an Interim Housing program for the purpose of continuing work on the goals outlined in the participant's or household's Housing and Services Plan. An Extension is not a requirement but affirms the eligibility of a participant or household to continue their stay an additional 90 days, and the potential of additional Extensions. There is no maximum time limit to a participant/household's term of stay in a shelter program.

This Form should not be used for a participant/household whose program stay will not be extended. Provider must ensure that reasons for a participant/household not being extended are documented as case notes in HMIS. link

The most current version of this form is available on the LAHSA website here
The aforementioned link is the current version of this form; if different from this document, please use the edition included on the LAHSA website.

PROVIDER INFORMATION			
PARTICIPANT NAME[1]:		**HMIS ID:**	
STAFF NAME:		**STAFF CONTACT EMAIL:**	
AGENCY NAME:		**SITE ADDRESS[2]:**	
IF FAMILY – Below, please describe household composition			
NUMBER OF ADULTS:		**NUMBER OF MINORS:**	

[1] If household, please enter the Head of Household (HoH)
[2] If DV shelter, omit the Site Address; if Vouchered, enter "Vouchered"

PROGRAM TYPE			
Which of following programs is the participant or household enrolled in? Check below.			
	Crisis Housing for Individual Adults / TAY		Bridge Housing for People Exiting Institutions (B7)
	Crisis Housing for Families – Motel Voucher		Enhanced Bridge Housing
	Crisis Housing for Families - Shelter		A Bridge Home
	Bridge Housing for Individual Adults / TAY		Roadmap Interim Housing
	DV Shelter		Project RoomKey / HomeKey
Date Enrolled in Current Program:			

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HOUSING & SERVICES PLAN - SUMMARY			
Below, please briefly summarize ***one goal*** from the Housing & Services Plan and the Action Step(s) agreed to toward this goal.			
GOAL: *(E.G. Reunification with Family member or friends)*			
	ACTION DESCRIPTION	**PERSON RESPONSIBLE (STAFF/PARTICIPANT)**	**ANTICIPATED COMPLETION DATE**
ACTION STEP # 1			
ACTION STEP # 2			
ACTION STEP # 3			

EXIT PLAN					
Does this participant / household currently have a move-in date to a permanent housing destination?			IF NO – Is it expected that the participant / household to exit to a permanent housing destination in the next 90 days?		
☐	YES		☐	YES	
☐	NO		☐	NO	
Planned Residence Address			**Move-In Date** - *MM/DD/YY*		/ /
(Street Address, Unit/Apt.#)		(City)	(State)		(Zip Code)

Program Supervision Name	
Program Supervision Signature, Date	/ /
Staff's Signature, Date	/ /
Participant Signature, Date	/ /