|  |  |
| --- | --- |
| Three County CoC HUD Intake Form | [Organization & Project Name Goes Here] |

# Client Information

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PROJECT START DATE (e.g., 08/24/2021) | | | | | | | | | | |
|  |  | / |  |  | / |  |  |  |  | The Project Start Date will be used as the information date for all data elements collected on this form. All data must be accurate as of this date, regardless of the date collected. |
| Month | |  | Day | |  | Year | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME | |  | NAME DATA QUALITY (HUD) | |
| First Name |  |  |  | Full name reported |
| *Middle Name \** |  |  |  | Partial, street name, or code name reported |
| Last Name |  |  |  | Client doesn’t know |
| Suffix |  |  |  | Client refused |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| GENDER Which of these genders best describes how the client identifies? Multiple options should be selected if the client identifies with more than one. | | | | | | |
|  | Female |  | Transgender |  |  | Client doesn’t know |
|  | Male |  | Questioning |  |  | Client refused |
|  | A gender other than singularly female or male (e.g. non-binary, genderfluid, agender, culturally specific gender) | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DATE OF BIRTH (e.g., 10/23/1978) | | | | | | | | | |  | DOB QUALITY (HUD) | |
|  |  | / |  |  | / |  |  |  |  |  | Full date of birth reported |
| Month | |  | Day | |  | Year | | | |  | Approximate or partial date of birth reported |
| Use 01/01/YEAR and select “approximate or partial date of birth” if client cannot recall DOB. | | | | | | | | | |  |  | Client doesn’t know |
|  |  | Client refused |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SOCIAL SECURITY NUMBER | | | | | | | | | | |  | SSN DATA QUALITY (HUD) | |
|  |  |  | - |  |  | - |  |  |  |  |  |  | Full SSN reported |
| Some projects may serve clients that do not have an SSN. In these cases, select “Client doesn't know”' | | | | | | | | | | |  |  | Approximate or partial SSN reported |
|  |  | Client doesn’t know |
|  |  | Client refused |

|  |  |  |
| --- | --- | --- |
| PRIMARY LANGUAGE |  | Interpreter Needed |

# Client Demographics

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ETHNICITY (HUD) | | | | |
|  | Non-Hispanic / Non-Latin(a)(o)(x) |  |  | Client doesn’t know |
|  | Hispanic / Latin(a)(o)(x) |  |  | Client refused |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| RACE (HUD) Check all that apply | | | | | | | |
|  | American Indian, Alaska Native, or Indigenous |  | Asian or Asian American |  | Black, African American, or African | | |
|  | Native Hawaiian or Pacific Islander |  | White |  | Client doesn’t know |  | Client refused |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| VETERAN STATUS (HUD) Does this client have a history of military service? **For adults only and heads of household who are 18 years of age and older.** A veteran is anyone who has ever been on active duty in the armed forces of the United States, regardless of discharge status or length of service. | | | | |
|  | No |  | Yes | **Branch:** |
|  | Client doesn’t know |  | Client refused |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | |
| *CELL PHONE \** |  |  |  | - |  |  |  | - |  |  |  |  | *DTA NUMBER \** |  |

# Universal Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | NAME OF HEAD OF HOUSEHOLD: |  |  RELATIONSHIP TO HEAD OF HOUSEHOLD (HoH) | | | | | |
|  | Self (head of household) |  | HoH’s child |  | HoH’s spouse or partner |
|  | HoH’s other relative |  | Other non-relative |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| If Self (head of household), list family members | | | |
| *Name \** | *DOB \** | *SSN \** | *Notes \** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| *EMERGENCY CONTACT INFORMATION \** | |
| Name |  |
| Relationship to Client |  |
| Phone |  |

|  |  |
| --- | --- |
| Name |  |
| Relationship to Client |  |
| Phone |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *PH and RRH Only* |  | IS THE CLIENT CURRENTLY IN PERMANENT HOUSING? | | | | | | | | | | | | | | | | |
|  | No |  | Yes |  | If Yes, Move-In Date: |  |  | / |  |  | / |  |  |  |  |
| Month | |  | Day | |  | Year | | | |

# Living Situation Prior To Project Start

|  |
| --- |
| WHAT WAS THE CLIENT'S RESIDENCE PRIOR TO PROJECT ENTRY? If the client moved around, but in the same type of situation, include the total time in that type of situation in Length of Stay. If the client moved around from one situation to another, only include the time in the situation selected. |

| Homeless Situations | Length of Stay in Homeless Situations |
| --- | --- |
| Place not meant for habitation  Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home Shelter  Safe Haven | One night or less  Two days to one week  One week or more, but less than one month  One to three months  More than three months, but less than one year  One year or longer  Client doesn’t know  Client refused |

| Institutional Situations | Length of Stay in Institutional Situations |
| --- | --- |
| Foster care home or foster care group home  Hospital or other residential non-psychiatric medical facility  Jail, prison, or juvenile detention facility  Long-term care facility or nursing home  Psychiatric hospital or other psychiatric facility  Substance abuse treatment facility or detox center | One night or less  Two days to one week  One week or more, but less than one month  One to three months  More than three months, but less than one year  One year or longer  Client doesn’t know  Client refused |

| Temporary and Permanent Housing Situations | Length of Stay in TH and PH Situations |
| --- | --- |
| Hotel or motel paid for without emergency shelter voucher  Owned by client, no ongoing housing subsidy  Owned by client, with ongoing housing subsidy  Permanent housing for formerly homeless persons  Rental by client, with no housing subsidy  Rental by client, with GPD TIP housing subsidy  Rental by client, with VASH housing subsidy  Rental by client, with other ongoing housing subsidy  Rental by client, with Housing Choice Voucher (HCV)  Rental by client, in a public housing unit  Rental by client, with RRH or equivalent subsidy  Residential project or halfway house with no homeless criteria  Staying or living in a family member’s room, apt., or house  Staying or living in a friend’s room, apt., or house  Transitional housing for homeless persons (including youth)  Host home (non-crisis) | One night or less  Two days to one week  One week or more, but less than one month  One to three months  More than three months, but less than one year  One year or longer  Client doesn’t know  Client refused |

|  |  |  |  |
| --- | --- | --- | --- |
| Other | | | |
|  | Client doesn’t know |  | Client refused |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| APPROXIMATE DATE HOMELESSNESS STARTED | | | | | | | | | | |
|  |  | / |  |  | / |  |  |  |  | Determine the date of the last time the client had a place to sleep that was not on the streets, in an emergency shelter, or in a safe haven. As the client looks back, there may be breaks in their stay on the streets, shelters, or safe havens. |
| Month | |  | Day | |  | Year | | | |

|  |
| --- |
| The breaks are allowed to be included in the look back period to calculate the start date only if:   * The client moved continuously between the streets, shelters, or safe havens. The date would go back as far as the first time they stayed in one of those places; OR * The break in their time on the streets, shelters, or safe havens was less than 7 nights. A break is considered 6 or less consecutive nights not residing in a place not meant for human habitation, in shelter or in a safe haven. The look back time would not be broken by a stay less than 7 consecutive nights; OR * The break in their time on the streets, ES, or SH was less than 90 days in any of the places listed under the header “institutional situations” on the previous page. The look back time would include all of those days (up to 89 days) when looking back for the start date. * If this is the client’s first day on the streets, shelters, or safe havens, enter today’s date. |

|  |  |  |  |
| --- | --- | --- | --- |
| NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN AN EMERGENCY SHELTER, OR A SAFE HAVEN IN THE PAST THREE YEARS INCLUDING TODAY Count the times a client has been homeless, separated by breaks, in the last three years. A break means at least 7 consecutive nights of not living on the street, in an emergency shelter, or Safe Haven or at least 90 days in any of the places listed under the header “institutional situations” on the previous page. | | | |
|  | One time (this time) |  | Four or more times |
|  | Two times |  | Client doesn’t know |
|  | Three times |  | Client refused |

|  |  |  |
| --- | --- | --- |
| TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN AN EMERGENCY SHELTER, OR A SAFE HAVEN IN THE PAST THREE YEARS Add up the total number of months homeless of all the different times the client has spent homeless on the streets, in shelter, or in safe havens in the past three years. Include any time a client spent in an institution for a period of less than 90 days or time spent in permanent or transitional housing for a period of less than 7 days. Responses may be rounded to the next-highest number of full months. The current month, even if a partial month, can be counted as a full month. | | |
|  | One month or less (choose if this is the first time the client has been homeless) | |
|  | Between 2 and 12 months (Enter number of months):\_\_\_\_\_ |  |
|  | More than 12 months | Notes: |
|  | Client doesn’t know |
|  | Client refused |

# Income and Benefits

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DOES THE CLIENT HAVE ANY INCOME FROM ANY SOURCE? | | | | |
|  | No |  | Yes | Notes: |
|  | Client doesn’t know |  | Client refused |

| Income Source | | Amount | | |  | Income Source | | | | Amount | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Earned Income | $ |  |  | | |  | Worker’s Compensation | $ | |  |
|  | Unemployment Insurance | $ |  |  | | |  | TANF | $ | |  |
|  | SSI | $ |  |  | | |  | General Assistance (GA) | $ | |  |
|  | SSDI | $ |  |  | | |  | Social Security Retirement | $ | |  |
|  | VA Disability Compensation | $ |  |  | | |  | Private Pension | $ | |  |
|  | VA Pension | $ |  |  | | |  | Child Support | $ | |  |
|  | Private disability insurance | $ |  |  | | |  | Alimony | $ | |  |
|  | Other (describe): | $ |  |  | | |  |  |  | |  |
|  |  |  |  |  | | |  | Total Monthly Income | $ | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DOES THE CLIENT HAVE ANY NON-CASH BENEFITS FROM ANY SOURCE? | | | | |
|  | No |  | Yes | Notes: |
|  | Client doesn’t know |  | Client refused |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Select all that apply | | | | |
|  | SNAP (formerly Food Stamps) |  | TANF transportation services | |
|  | WIC |  | Other TANF-Funded Services | |
|  | TANF Child Care services |  | Other source: |  |

# Health Insurance

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| IS THE CLIENT CURRENTLY COVERED BY HEALTH INSURANCE? | | | | |
|  | No |  | Yes | Notes: |
|  | Client doesn’t know |  | Client refused |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Select all that apply | | | | |
|  | Medicaid (MassHealth) |  | COBRA | |
|  | Medicare |  | Private Pay Health Insurance | |
|  | Children’s Health Insurance Program |  | State Health Insurance for Adults | |
|  | Veteran’s Administration (VA) Medical Services |  | Indian Health Services Program | |
|  | Employer-Provided Health Insurance |  | Other source: |  |

# Health and Wellness Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the client have a **mental health** condition? | Yes | No | DK | Refused |
| Is it of long duration while impairing their ability to live |  |  |  |  |
| independently? | Yes | No | DK | Refused |
|  |  |  |  |  |
| Does the client have a **substance use** disorder? | Yes | No | DK | Refused |
| If yes, what kind? | Alcohol use | Drug use | Both alcohol and drug use | |
| Is it of long duration while impairing their ability to live  Independently? | Yes | No | DK | Refused |
|  |  |  |  |  |
| Does the client have a **developmental disability**? | Yes | No | DK | Refused |
|  |  |  |  |  |
| Does the client have a **physical disability**? | Yes | No | DK | Refused |
|  |  |  |  |  |
| Does the client have a **chronic health condition**? | Yes | No | DK | Refused |
|  |  |  |  |  |
| Does the client have **AIDS/HIV**? | Yes | No | DK | Refused |
|  |  |  |  |  |
| \*Is the client **pregnant**? NA | Yes | No | DK | Refused |
| Due Date: | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| IS CLIENT A DOMESTIC VIOLENCE VICTIM/SURVIVOR? | | | | |
|  | No |  | Yes | Notes: |
|  | Client doesn’t know |  | Client refused |

|  |  |  |  |
| --- | --- | --- | --- |
| If yes, when did the last episode occur? | | | |
|  | Within the past three months |  | One year ago or more |
|  | Three to six months ago (excluding six months exactly) |  | Client doesn’t know |
|  | Six months to one year ago (excluding one year exactly) |  | Client refused |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| If yes, is the client currently fleeing? | | | | | | | |
|  | No |  | Yes |  | Client doesn’t know |  | Client refused |

**Well-being (Permanent Supportive Housing only)**

*Please discuss with clients how they would rate the following statements*

Client perceives their life has value and worth:

|  |  |  |  |
| --- | --- | --- | --- |
| Strongly disagree | Somewhat disagree |  | Neither agree nor disagree |
| Somewhat agree | Strongly agree |  | Client doesn’t know |
| Client refused |  |  |  |

Client perceives they have support from others who will listen to problems:

|  |  |  |  |
| --- | --- | --- | --- |
| Strongly disagree | Somewhat disagree |  | Neither agree nor disagree |
| Somewhat agree | Strongly agree |  | Client doesn’t know |
| Client refused |  |  |  |

Client perceives they have a tendency to bounce back after hard times:

|  |  |  |  |
| --- | --- | --- | --- |
| Strongly disagree | Somewhat disagree |  | Neither agree nor disagree |
| Somewhat agree | Strongly agree |  | Client doesn’t know |
| Client refused |  |  |  |

Client’s frequency of feeling nervous, tense, worried, frustrated, or afraid:

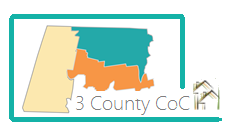
|  |  |  |  |
| --- | --- | --- | --- |
| Not at all | Once a month |  | Several times a month |
| Several times a week | At least every day |  | Client doesn’t know |
| Client refused |  |  |  |

**General Health Status (Permanent Supportive Housing only)**

WHAT IS THE CLIENT’S GENERAL HEALTH STATUS?

|  |  |
| --- | --- |
| Excellent | Poor |
| Very Good | Client doesn’t know |
| Good | Client refused |
| Fair | Data not collected |

**You’ve reached the end of the intake. Thank you very much for your time!**



**Homeless Verification Form**

1. Current Housing Situation

I certify that

* Is living in a place not meant for human habitation, such as cars, parks, sidewalks, abandon buildings or on the street.

#### **Verification: Please attach statement of situation and signature of current service provider.**

* Is staying in an emergency shelter for homeless persons.

#### **Verification: Please attach a statement of situation with signature of shelter staff.**

* Is in a transitional or supportive housing program for homeless persons and/or in any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.

#### **Verification: Please attach statement of situation and signature of transitional/supportive housing staff.**

* Is a temporary resident in a hotel/motel through sponsorship by a social service agency or hotel voucher program. No subsequent residence has been identified and the person lacks the resources and support needed to obtain housing.

#### **Verification: Please attach statement of situation, proof of hotel voucher, and signature of current service provider.**

* Is being evicted or forced out within a week from a private dwelling unit, no subsequent residence has been identified and the person lacks the resources and support needed to obtain housing.

#### **Verification: Attach statement of situation and signature of private dwelling owner or staff member.**

* Is being discharged from an institution, such as mental health or substance abuse treatment facility or jail or prison in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks necessary to obtain housing.

#### **Verification: Please attach statement of situation and signature of institution staff member.**

* Is fleeing a domestic violence housing situation and no subsequent residence has been identified and the person lacks the resources and support necessary to obtain housing.

#### **Verification: Please attach statement of situation and signature by the individual.**

### Homeless Verification Form

Statement of current situation: (Attach separate sheet if needed)

### 2) Housing History

Please describe this individual’s housing situation for the past three years:

Does this person meet HUD’s definition of Chronically Homeless?

#### **Chronically homeless is defined as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4)episodes of homelessness in the past three (3) years.”**

Yes, this person is chronically homeless: Complete the chronic homeless verfication form.

No. He/she is currently but not chronically homeless.

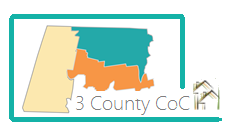
Required signature (see above)

Date Organization/Title:

Applicant Signature:

Date Case Manager/Staff signature:

Date



**Chronically Homeless Qualification Checklist**

**Instructions:** This suggested checklist may be used as a guide for staff of a program serving chronically homeless persons to assure that participants meet program eligibility. It should be accompanied by supporting documentation of both disability and homelessness. These documents must be maintained in the client’s file.

Client Name:

HUD defines a Chronically Homeless person as: an unaccompanied homeless person with:

**Part I**. A Disabling Condition. *Check appropriate box(es):*

A diagnosable substance abuse disorder A serious mental illness

A developmental disability

A chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Part I is supported by a letter from a medical professional attesting to the presence of the condition.

Yes No

**Part II.** Chronically Homelessness Status. Check ONE:

Has been continuously homeless for a year or more.

*(HUD defines “homelessness” as “sleeping in a place not meant for human habitation e.g. living on the streets OR living in a homeless emergency shelter.)*

Has had four (4) episodes of homelessness in the last three (3) years.

*(HUD defines “homelessness” as “sleeping in a place not meant for human habitation e.g. living on the streets OR living in a homeless emergency shelter.)*

Part II is supported by Third Party Certification, which includes dates and locations of homelessness, from one or more of the following: *Check ALL that apply*

Certification letter(s) from an emergency shelter for the homeless. Certification letter(s) from a homeless service provider or outreach worker. Certification letter(s) from any other health or human service provider.

Certification Self-Statement signed by the client.

Staff Name: Staff Title:

Organization:

Signature: Date:

### Chronically Homeless Qualification - Third Party Verification

**Instructions**: This form or similar may be completed by the certifying agency. This recommended template can be copied onto letterhead or recreated with the same content and printed on letterhead.

### Certification

I certify that stayed at (Client’s Name) (Facility/ Program Name)

for the following period of time:

(1) between: / / and : / / (2) between: / / and : / / (3) between: / / and : / / (4) between: / / and : / /

*Additional detail about the client’s episodes of homelessness may be written below.*

Before coming to this facility, the homeless person resided at .

|  |
| --- |
| This facility is classified as one of the  following types of facilities/programs: |

Emergency Shelter

Transitional Housing

Permanent Housing

Medical Institution

Correctional Facility

Substance Abuse Facility

Mental Health Institution

Other

Signature: Date: (Signature of Facility Staff)

Title: Phone:

### Chronically Homeless Qualification - Self-Statement Certification

**Instructions:** This template for a Self-Statement Certification may be used when a homeless person applying to a program serving chronically homeless persons lacks connections with service providers to complete a Third Party Verification of a history of chronic homelessness. It should be maintained in the client’s file.

I certify that I was homeless (that is sleeping in a place not meant for human habitation such as living on the streets) **OR** living in a homeless emergency shelter during the following period(s) of time:

Between *Example*: Jan., 2009 and *Aug., 2009* I lived at *Worcester Shelter*

Between and I lived at

Between and I lived at

Between and I lived at

Between and I lived at

Between and I lived at

Between and I lived at

What else would you like to share about your history?

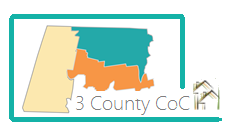
For example, *“I cannot remember the name of the place where I was living during the fall of 2010 but I believe that it was a homeless emergency shelter. I have problems with my memory due to an illness.”*

I certify that the above information is correct.

(Signature of Client) (Date)

I reviewed the above statement with the client.

(Signature of Staff Witness) (Organization) (Date)



**Documentation of Disability**

**Instructions:** All participants in HUD-funded Permanent Supportive Housing programs and Chronic Homeless programs should have verification of their disabling condition. Documenting verification may be done in several ways, as noted below. Place this form and its attachments in the client’s file.

Client Name:

Date:

### Specify the method of verifying the disability by checking the appropriate box. Only one method is required.

* Written verification of the disability from a professional licensed by the state to diagnose and treat the disability, and their certification that the disability is expected to be long or indefinite in duration and while substantially impeding the individual’s ability to live independently.

#### **Attach the certification. A sample is provided on the following page.**

* Written verification from the Social Security Administration.

#### **Attach the verification letter.**

* The receipt of a disability check.

#### **Attach a copy of the SSI/SSDI check.**

* Intake staff-recorded observation of a disability that, no later than 45 days of the application for assistance, is confirmed and accompanied by evidence as specified above.

#### **Enter the date that is 45 days from the application: (mm/dd/yyyy)**

**Documentation of Disability**

INSTRUCTIONS: A qualified professional with one of the following credentials (MD, DO, LCPC, LCSW, APRN-BC, NP) must complete this form. Sections 1, 2 and 3 of the form apply to:

DOB:

### SECTION 1: APPLIES TO INDIVIDUALS WITH PSYCHIATRIC DISABILITIES, CHRONIC SUBSTANCE ABUSE AND HIV/AIDS

The above named individual is an adult having a physical, mental, or emotional impairment that:

1. is expected to be of long-continued and indefinite duration

### AND

1. substantially impedes the person’s ability to live independently

### AND

1. is such that the person’s ability to live independently could be improved by more suitable housing conditions.

If a, b, and c above are true then please check ‘Yes’, otherwise check ‘No’

YES

NO

### SECTION 2: APPLIES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

The above named individual is an adult with a chronic developmental disability which:

* 1. is attributable to a mental and/or physical impairment or combination mental and physical impairments; **AND**
  2. was manifested before the person attained age 22; **AND**
  3. is likely to continue indefinitely; **AND**
  4. results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self- direction; capacity for independent living; and economic self-sufficiency; **AND**
  5. reflects the person’s need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are of lifelong, or extended duration and are individually planned and coordinated.

If a, b, c, d, and e are true then please check ‘Yes’, otherwise check ‘No’ YES NO

### SECTION 3: APPLIES TO ALL APPLICANTS

The individual named above is an individual with:

*(Check all that apply)*

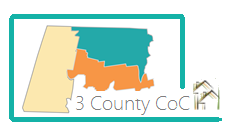
A Psychiatric Disability Chronic Alcohol Abuse

HIV/AIDS Chronic Substance Abuse

Other Disability

### Name and credentials of Provider Agency and Telephone Number

**Signature Date**



**Income Verification Form**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please Complete either Part I or Part II*

**I. If applicant household has source(s) of income**

Anyone that is/will be living in the household that is currently receiving income (employment, SSI, SSDI, OWF/TANF, retirement, Social Security, etc.), must complete this section.

I/we certify that as of (mm/dd/yyyy), my source(s) of income are as follows:

$ Source Amount Income for which household member

$ Source Amount Income for which household member

**Please provide income documentation for each source of income (statement from the source of income- SSI, SSDI, Social Security, EA/TANF, and/or copy of last three months of payroll/benefit checks). Continue on back if necessary.**

**II. If applicant household does not have a source of income**

If there is currently no household, please complete this section.

I/we certify that as of (mm/dd/yyyy), I/we have no source of income.

|  |
| --- |
| By signing this document, I/we certify that the above information is true and accurate to the best of my knowledge. I/we understand that the agency will be verifying this information and failure to provide correct information could lead to ineligibility for potential assistance from the program.  *Must be signed by all adult household members and adolescents that are employed.*    Signature Date    Signature Date    Signature Date |