

**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.

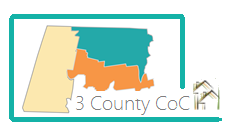
Required signature (see above)

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?

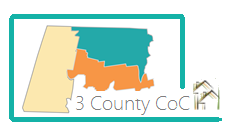
For example, *“I cannot remember the name of the place where I was living during the fall of 2010 but I believe that it was a homeless emergency shelter. I have problems with my memory due to an illness.”*

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**