HUD CHRONIC HOMELESSNESS - VERIFICATION PACKET

Client Name: _____ Client DOB: _____ Date Completed: _____

There are several steps to verifying that someone meets the HUD definition for chronic homelessness*. This worksheet will guide you through those steps. Please follow along below. If you get stuck see the quick reference on page 3. ***Remember – "Homeless" below means living in a place not meant for human habitation, in an emergency shelter/motel voucher program or a safe haven. Individuals in transitional housing are not considered chronically homeless but do meet the definition of "homeless" for other HUD and non-HUD programs.***

Section 1: Current Living Situation

1) Is this individual *currently* homeless, living in an institutional living setting, or in a rapid re-housing program? Institutional living includes inpatient treatment, acute care facilities like hospitals and skilled nursing, and criminal justice institutions. □ Yes □ No

● *If no, **STOP**, this individually is not chronically homeless.*

● *If the individual is currently homeless, **GO** to Section 2.*

a) If the individual is living in an institutional setting, have they been there less than 90 days and were they homeless upon entry to the institutional setting? □ Yes □ No

b) If the individual is enrolled in a rapid re-housing program, have they been in the program for less than 24 months and were they homeless upon entry to the program? □ Yes □ No

● *If no to both a and b, **STOP**, this individually is not chronically homeless.*

Section 2: **Disability Verification**

Does this individual have a diagnosed and documented health condition expected to be of long-continued and indefinite duration AND substantially impedes their ability to live independently AND is of such a nature that the ability to live independently could be improved by more suitable housing conditions? □ Yes □ No

● *If this person does not have a disability, **STOP**, this individually is not chronically homeless.*

Section 3: Duration of Homelessness

Has this individual been homeless for at least one year continuously; **OR** have they experienced at least four separate homeless occasions over 3 years with a break of at least 7 days between each occasion; AND does the total amount of time homeless in the last three years add up to at least 12 months? Use the housing history chart on the next page to guide your response. □ Yes □ No

● *If no, **STOP**, this individually is not chronically homeless.*

● ***If yes, this individual is chronically homeless. Continue to Section 4.***

*https://files.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

Section 4: Documenting Chronic Homelessness

Now it is time to gather documentation to verify chronic homelessness. HUD requires the following documentation:

a. Evidence of current homeless status; AND
b. Evidence of the duration of homelessness
    i. Evidence that the current homeless occasion has been continuous, for at least one year; OR
    ii. Evidence that the household experienced at least four separate homeless occasions over 3 years with a break of at least 7 days between each episode; AND the total amount of time homeless in the last three years is at least 12 months
c. Evidence of diagnosis of one or more of the following disabling conditions: substance use disorder, serious mental illness, developmental disability, chronic health condition, HIV, and/or physical disability

Note: One documented encounter, physical observation of living situation, or HMIS record indicating homelessness within a month is sufficient to verify homelessness for the entire calendar month as long as there is no other evidence indicating a break in homelessness for that month.

A. To determine what documentation is needed to verify current homelessness and duration of homelessness review the statements below. Use the type of documentation that is appropriate to verify homelessness for each month needing verification. Multiple types of documentation may be needed. Please see the templates on the subsequent pages.

    □ I have access to the Homeless Management Information System (HMIS) and this individual has record(s) of a project entry for emergency shelter/voucher program.
        ➢ **Print the record of project entry from HMIS**. Print out must show individual's name and dates of enrollment.

    □ I have access to HMIS and this individual has HMIS outreach contacts documented in HMIS.
        ➢ **Print the record of outreach contact(s) from HMIS**. Print out must show individual's name and date(s) of contact(s).

    □ I physically observed the place this individual is/was living while acting in my professional capacity or I am using my professional judgement to determine this person is/was homeless at the time of my encounter(s) with them.
        ➢ Complete **Professional Assessment of Living** Situation form.

    □ I did not physically observe the place this individual is/was living. I received an oral/written statement from another community member (i.e. a shopkeeper, a building owner, or a neighborhood resident) who physically observed the place this individual is/was living.
        ➢ Complete **Summary of Witness Statement** form.

    □ There is no third-party who can verify this individual's living situation. No more than 3 months of the 12 documented months can be verified by self-certification.
        ➢ Complete **Self-Certification of Homeless** form *with client.*

B. To document verification of disability a licensed health care professional, who can diagnose and treat the condition being verified, needs to complete the **Verification of Disability** form that can be found on the last page of this packet.

If you have questions, contact Home Stretch at HomeStretch@acgov.org or (510) 567-8017.
To access additional forms and information about Home Stretch, visit http://everyonehome.org/our-work/home-stretch/.

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HUD Homeless Definition Living Situation Quick Reference

Applicant's Current Living Situation	**Is applicant considered Literally Homeless in this housing?**	**Is the applicant considered *currently* homeless for CH purposes?**	**Does time in this housing count as time homeless for CH purposes?**	**Notes**
Emergency Shelter	Yes	Yes	Yes	
Place not meant for human habitation	Yes	Yes	Yes	
Transitional Housing (TH)	Yes	No	No	A stay in TH of 7 days or more is considered a break in homelessness. Only programs publicly funded as transitional housing fit this category.
Rapid Rehousing (RRH)	Yes*	Yes*	No	*If less than 24 months in RRH and the person was literally homeless upon program entry.
Institutional Living Setting (Examples: acute medical facility, inpatient substance use or mental health treatment, crisis residential, hospital, jail)				
Less than 90 days	Yes, if the person was literally homeless upon program entry.	Yes, if the person was literally homeless upon program entry.	Yes, if the person was literally homeless upon program entry.	
More than 90 days	No	No	No	Stays in institutions of 90 days or more constitute a break in homelessness and do not count toward total time homeless.
Hotel/Motel				
Paid for by agency/voucher	Yes	Yes	Yes	If the hotel is paid for by an agency to divert the person from shelter or the streets, they retain homeless status.
Paid for by applicant, relatives, friends or others (7+ nights)	No	No	No	If the hotel stay is less than 7 consecutive nights the person retains their homeless status.
Staying with Friends or Family/Couch Surfing				
Less than 7 consecutive nights	Yes	Yes	Yes	
Seven (7) or more consecutive nights	No	No	No	
Other				
Sober Living	No	No	No	Transitional residential and limited-term recovery programs are institutional living.
Board and Care	No	No	No	

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Housing History Chart

(for tracking documentation needed)

Locations over the last three years, starting with the present. Please include street(s) and city. Verification beyond 12 months is not needed for individuals who have been continuously homeless for the past 12 months.	**Type of Living Situation** Emergency Shelter (ES), Place Not Meant for Habitation (PNMH), Transitional Housing (TH), Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), Institution (INST), Not Homeless (NH)	**Start Date**	**End Date**	**Total Months**	**Verification Available From?** Verification is required for all time spent living in a homeless situation.
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH
	☐ ES ☐ PNMH ☐ TH ☐ PSH ☐ RRH ☐ INST ☐ NH				☐ HMIS ☐ Professional Assessment ☐ Witness ☐ Self-Certification ☐ NH

(Revised 10/25/19)

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*****IMPORTANT, PLEASE READ*****

Please provide verification of homelessness on ***your agency letterhead***. The recommended template below may be copied onto letterhead or recreated with the same content and printed on letterhead.

Professional Assessment of Living Situation

This form should be utilized to verify homelessness for months in which a service provider, acting in their official capacity, had an encounter with a client and, based on their knowledge and professional opinion, believe that the individual or head of household was living in a place not meant for human habitation, an emergency shelter, or a safe haven at the time of the encounter. The service provider may have physically observed the individual living in a place that is consistent with the HUD definition of literal homelessness or they may have had an encounter in another setting and during that encounter there was evidence that led the service provider to conclude that the individual was living in a situation consistent with the HUD definition of literal homelessness. One encounter within a month is sufficient to verify homelessness for the entire calendar month. Service providers include outreach workers, housing navigator, healthcare professionals, members of law enforcement, and case managers. **For each location that you can verify the applicant was living, complete all information requested. At least one observation per month is required by HUD.**

----------COPY SECTION BELOW ON TO AGENCY LETTERHEAD OR USE SIMILAR TEXT ON AGENCY LETTERHEAD----------

Applicant Name: _____ Date of Birth: _____

For each location in which the applicant was living, complete all information requested.

Location of encounter (encampment location, cross streets, name of clinic, address, office location, etc.):	Statement detailing the aspects of the interaction that indicated the Applicant was experiencing homelessness at the time of the encounter (physical observation of the Applicant's living situation, Applicant explained their living situation, Applicant was carrying their belongings with them, Applicant seemed stressed about their living situation, etc.):	Presumed location Applicant was living (address, name of public space, street name, landmark, etc.):	Presumed living situation of Applicant (in car, in a tent, on the street, in emergency shelter etc.):	Date of encounter: (MM/DD/YYYY)

I certify that information described above is accurate and that, based on my professional opinion, the applicant was experiencing homelessness at the time of the encounter(s).

_____

Printed Name Organization Title/Role

_____

Signature Date Phone Email

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*****IMPORTANT, PLEASE READ*****

Please provide verification of homelessness on ***your agency letterhead***. The recommended template below may be copied onto letterhead or recreated with the same content and printed on letterhead.

Summary of Witness Statement

This form should be utilized by a service provider to verify homelessness for months in which a community member, such as a shop keeper or neighborhood resident, physically observed an individual or head of household living in a place not meant for human habitation and provided an oral or written description of their observations to the service provider. The community member must indicate which approximate dates they observed the individual or head of household residing in a place not meant for human habitation and the location. The service provider must use their professional judgement to determine if the source is reliable. **For each location in which the applicant was observed to be living, complete all information requested. At least one observation per month is required by HUD.**

----------COPY SECTION BELOW ON TO AGENCY LETTERHEAD OR USE SIMILAR TEXT ON AGENCY LETTERHEAD----------

Applicant Name: _____ Date of Birth: _____

Community Member Name: _____ Relation to Applicant: _____

Phone Number (if available): _____

For each location in which the community member observed the Applicant living, complete all information requested.

Location (address, name of public space, street name, landmark, etc.):	Description of living conditions observed (sleeping in a car, in a tent, in the open, etc.):	Date observed:

I certify that the information above was reported to me by the listed community member and I believe it to be an accurate account.

_____

Printed Name Organization Title/Role

_____

Signature Date Phone Email

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Homelessness Self Certification Statement

Instructions: *This form may be used when an applicant lacked connections with service providers to complete a third-party verification of homelessness during a time period for which homelessness must be verified. Service providers must document all attempts to obtain third party verification for each self-certification (see below).*

Applicant Name: _____ Date of Birth: _____ Phone or E-mail: _____

I certify that I have been homeless during the following periods of time and in the following locations.

Location (address, name of public space, street name, landmark, etc.):	Description of living conditions (sleeping in a car, in a tent, in the open, etc.):	Start date:	End date:

What else would you like to share about your homeless status during the period of time referenced above (optional)? For example, *"I cannot remember the name of the place where I was living during the fall of 2018 but I believe it was an emergency shelter. I have problems with my memory from that time due to an illness."*

_____

_____

I certify that the above information is correct.

Signature of Client: _____ Date of Signature: _____

Staff Section: *DO NOT SKIP THIS STEP*

Please document all attempts to obtain 3rd party verification for the period of homelessness documented above.

1) _____

2) _____

3) _____

I reviewed the above statement with the applicant and certify that the attempts to obtain third-party verification are accurate.

Name of Staff (Print): _____

Staff Member Organization and Title: _____ Staff Phone Number: _____

Signature of Staff: _____ Date of Signature: _____

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Guide to Home Stretch Disability Verification

Instructions: Use this information as a guide when documenting disability for a Home Stretch referral. Include appropriate disability verification to enable matching to specific housing opportunities.

According to HUD guidelines, a person shall be considered to have a disabling condition if such a person has a diagnosable:

- Substance use disorder; AND/OR
- Serious mental illness; AND/OR
- Development disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000, (42 U.S.C. 15002); AND/OR
- Post-traumatic stress disorder (PTSD); AND/OR
- Cognitive impairments resulting from brain injury; AND/OR
- Chronic physical illness or disability (e.g. HIV/AIDS)

And that condition meets all of the criteria below:

- Is expected to be of long-continued and indefinite duration; AND
- Substantially impedes the person's ability to live independently; AND
- Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.

There are specific housing opportunities with set-asides or preferences for people with the following health conditions: HIV/AIDS, serious mental illness, developmental disabilities, and substance use conditions. Please have a licensed health care professional complete the **Home Stretch Disability Verification** to be considered for these specific housing opportunities.

If a licensed health care professional CANNOT complete the disability verification, then disability can also be verified by providing one of the documents listed below. However, it is strongly recommended that the **Home Stretch Disability Verification** be completed if possible.

Disability can also be verified by providing one of the documents listed below:

- Written verification of disability from the Social Security Administration, OR

- Copy of a disability check (e.g., Social Security Disability Insurance check or Veteran's Disability Compensation)

*https://files.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

Home Stretch Disability Verification

To Be Completed By A Licensed Health Care Professional

This verification will help prioritize homeless and disabled individuals for permanent supportive housing opportunities in Alameda County.

This Disability Verification Form is for:

Patient Name: _____

Patient Date of Birth: _____

Clinician Contact Information:

Organization Name (if applicable): _____

Address: _____

Phone #: _____

E-mail: _____

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of patients. Within my scope of practice, I have determined that the patient named above has the following diagnosable condition(s) that are: 1) expected to be of long-continued and indefinite duration; AND 2) substantially impedes the individual's ability to live independently; AND 3) The condition could be improved by more suitable housing conditions. (check ALL that apply):

- ☐ Substance use disorder**
- ☐ Serious mental illness, including severe Post Traumatic Stress Disorder (as defined in the DSM and is severe in degree and persistent in duration; is NOT a substance use disorder, developmental disorder, or acquired traumatic brain injury)**
- ☐ Developmental disability (as defined in Section 102 of the Development Disabilities Assistance Bill of Rights Act of 2000, {42 U.S.C. 15002})**
- ☐ Cognitive impairments resulting from brain injury**
- ☐ Chronic physical illness or disability*
- ☐ HIV infection or AIDS*

***Acceptable Credentials for Medical Conditions:** *MD* (Medical Doctor), *NP* (Nurse Practitioner)
****Acceptable Credentials for Mental Health & Substance Use Conditions:** *MD* (Medical Doctor), *NP* (Nurse Practitioner), *PsyD/ PhD* (Psychologist), *LCSW* (Licensed Clinical Social Worker), MFT/*LMFT* (Marriage and Family Therapist), *LPCC* (Licensed Professional Clinical Counselor)

My signature below indicates my verification of the above information for this patient.

Intern Name, if applicable (printed): _____

Signature: _____ Date: _____

Licensed Staff Name (printed): _____

Signature: _____ Date: _____

Professional License Type: _____ License #: _____

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