Case Conference Documentation Submission Guide

Send all documents through the Submission Portal: https://vchsa.org/hmis-submit/form/en

This optional tool is to assist you in verifying that ALL required documents are included with your packet for case conference consideration. ***Completed packets MUST be received by NOON on Wednesday the week before case conference. Incomplete packets may cause delay in scheduling.***

NOTE: Documentation MUST be for the client being referred for Case Conference.
Household member or companion documentation will not be accepted.

For Permanent Housing (PH) w/Disability, Literal or Imminent Risk of Homelessness, or Fleeing Domestic Violence:

- ☐ Case Conference form
- ☐ VC CoC Homeless Certification Documentation Packet:
  - ☐ Pages 1-4 *(checklist and client information)*
  - ☐ Page 5-7 *(self-statement or verifications specific to client)*
  - ☐ Page 8 *(for PH w/Disability only; SSI or SSDI statement acceptable)*
  - ☐ Page 9 *(for PH w/Disability only;* ***MUST*** *be completed* ***regardless*** *of page 9 or SSI/SSDI submittal)*
  - ☐ Page 10 *(client certification)*
- ☐ Current Vulnerability Assessment Tool (VAT) *(Please send with packet* ***in addition*** *to uploading to HMIS)* ***–OR—*** At-Risk Prioritization Tool *(if client is at risk)*
- ☐ If HMIS history is being utilized as verification of homelessness, please include a printout from the client's Entry/Exit tab.
- ☐ New or updated HMIS entry in CES Pathways to Home (197). Also complete the "Coordinated Entry Assessment" at the bottom of the page including your provider information and run an eligibility module.

For Chronic Homelessness:

- ☐ Case Conference form
- ☐ VC CoC Chronic Homeless Documentation Packet:
  - ☐ Pages 1-3 *(checklist and client information)*
  - ☐ Page 4 *(housing history)*
  - ☐ Page 5 *(if breaks are indicated)*
  - ☐ Pages 6-8 *(self-statement or verifications specific to client)*
  - ☐ Page 9 *(certification of disability)*—**OR**—SSI/SSDI statement.
  - ☐ Page 10 *(****MUST*** *be completed* ***regardless*** *of page 9 or SSI/SSDI submittal)*
  - ☐ Page 11 *(client certification)*
- ☐ Current Vulnerability Assessment Tool (VAT) *(Please send with packet* ***in addition*** *to uploading to HMIS)*
- ☐ If HMIS history is being utilized as verification of homelessness, please include a printout from the client's Entry/Exit tab.
- ☐ New or updated HMIS entry in CES Pathways to Home (197). Also complete the "Coordinated Entry Assessment" at the bottom of the page including your provider information and run an eligibility module.

For Transitional Housing:

- ☐ Case Conference form
- ☐ Current Vulnerability Assessment Tool (VAT) —**AND/OR**—At-Risk Prioritization Tool. *(Please send with packet* ***in addition*** *to uploading to HMIS)*

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Ventura County Continuum of Care
Chronic Homeless Documentation Checklist

Instructions: This recommended checklist should be used as a guide to confirm chronic homeless eligibility. It should be accompanied by supporting documentation of both disability and length of time homeless. Please use the attached forms, to satisfy HUD requirements for Permanent Supportive Housing eligibility.

DISABILITY DOCUMENTATION
Check and include documentation of one of the following. The diagnosis must be verified and documented by a licensed professional who can diagnose and is currently treating the condition.

- ☐ A diagnosable substance abuse disorder causing an impairment due to alcohol or drug abuse
- ☐ A developmental disability
- ☐ A serious mental illness
- ☐ A posttraumatic stress disorder, or brain injury
- ☐ A chronic physical illness or disability, including the co-occurrence of two or more of these conditions.
- ☐ Other

Supportive Documentation Required for Disability (*attach one*)

- ☐ A letter from a medical professional attesting to the presence of the condition and is signed by a licensed professional that is able to diagnose and treat in the state of California.
- ☐ (SSI, SSDI or Veteran's Disability) A written verification from the SSA/VA or a copy of the disability check is attached.

CHRONIC HOMELESS STATUS:

An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months). Breaks in homelessness, while the individual is residing in an institutional care facility will not count as a break in homelessness. Additionally, an individual who is currently residing in an institutional care facility for less than 90 days and meets the above criteria for chronic homelessness may also be considered chronically homeless. Lastly, a family with an adult/minor head of household who meets the above-mentioned criteria may also be considered chronically homeless, despite changes in family composition (unless the chronically homeless head of household leaves the family). This applies to all project participants admitted on January 15, 2016 and after.

Supportive Documentation Required for CH status: Attach one including the dates and locations of homelessness, from one or more of the following. Documentation must include coverage of a total of 12 months (documentation for each month). Examples of documentation to be included are listed below:

- ☐ 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.
- ☐ Documentation from HMIS or similar database

Reviewed On: _____ _____
Signature (SME)

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Additional Supportive Documentation for Veterans and Income:

Supportive Documentation Required Veteran Status *(if applicable):*

☐ The DD Form 214, Certificate of Release or Discharge from Active Duty
Additional questions:

1) Yes ☐ or No ☐: Person served in the active military, naval or air service of the U.S. or as a member of the National Guard for a period of not fewer than 90 consecutive days or was discharged from service due to a service-related disability. This includes veterans with other-than-honorable discharges.
2) Yes ☐ or No ☐: Is the Veteran connected to VA Healthcare? If no, refer to Oxnard VA Clinic 805-204-9135 to establish healthcare services.
3) Yes ☐ or No ☐: The DD 214 Form is attached. If no, refer to Veteran Services Office 805-477-5155 to make an appointment.

Supportive Documentation Required for Income Verification *(if applicable):*
Third-party income verification will be required from all sources, including but not limited to:

☐ Employment, Self-Employment
☐ Savings and checking
☐ Pension
☐ Disability
☐ Asset verification, property, home, stocks, bonds, annuities, IRA, etc.
☐. Government assistance, A.F.D.C., food stamps, etc
☐ Social Security
☐ Child Support/Alimony
☐ Non-Tuition Financial Aid.

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Client Name:	**Date of Birth:**
Number in Household:	**Client Head of Household:** ☐ Yes ☐ No

Part 1: Current Housing Status

Client must currently be in one of these locations in order to be considered chronically homeless.

Client is currently residing:

☐ In an Emergency Shelter

☐ On the Streets/Place not Meant for Human Habitation (car, encampment, etc)

☐ In a Safe Haven

☐ In an Institutional Care Facility (Where they have been for fewer than 90 days)

Start Date: _____	**End Date:** _____

Location Name/Address:

Current Housing Status Notes:

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Part 2: Housing History

	Month # 1	Month # 2	Month # 3	Month # 4	Month # 5	Month # 6	Month # 7	Month # 8	Month # 9	Month # 10	Month # 11	Month # 12
Mo./Yr.	(Current Month)											
Location *Check all that Apply*	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)
Doc. Type *Check One* *(Except Self-Cert. select both)*	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker	Third party observation ☐ HMIS ☐ Obsv. Outreach wrkr/case manager ☐ Obsv. by Comm. worker
	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.	☐ Self-Cert.
	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral	☐Referral
	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork	Breaks ☐Discharge Paperwork
Doc. Att.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Break Mo./Yr. & Descr. or N/A	Break 1: Break 2: Break 3: If there are additional breaks please detail and attach.
Notes	
Self-Cert. Check	Does the documentation include more than 3 Months of Self-Certifications? * ☐ Yes ☐ No ** Please be advised that if you answered **YES**, that for at least 75% of the households assisted by a recipient in a project during an operating year, no more than 3 months can be self-certified. **Please check with you project administrator to ensure your project has not exceeded its self-certification cap.*****
Key	*Mo. = Month, Yr. = Year, Inst. = Institution, Doc. = Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description*

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Third Party Verification of Homeless Status

***Instructions**: This form can be completed by an outreach work, social service provider, healthcare provider, law enforcement officer, shop keeper, neighbor, friend, community member or qualified person who can verify the client's homeless status. A letter or email from a provider is also acceptable documentation.*
(Full year and multiple verifiers acceptable).

*Please specify where you **physically witnessed/observed** the client living and your relationship to the client:*

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dates: ___Month_/__Day___/__Year__ (example)

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____,_____/_____/_____, _____/_____/_____,

_____/_____/_____,_____/_____/_____, _____/_____/_____

I certify that_____has been homeless and staying in places not meant for human habitation or emergency shelters for the periods of time listed above:

Signature:_____ Date:_____

Title: _____ Phone: _____

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Referral from Outside Service Provider Verification of Homeless Status

Instructions*: This form can be completed by a social service provider, healthcare provider, or qualified person who provided services to the client and the client reported they are homeless. A letter or email from a provider is also acceptable documentation.*

Please specify where your ***client presented for services, where they reported to be living*** *and your relationship to the client* **(Maximum of 3 months)***:*

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dates: ___Month_/__Day___/__Year__ (example)

_____/_____/_____, _____/_____/_____, _____/_____/_____

I certify that_____has been homeless and staying in places not meant for human habitation or emergency shelters for the periods of time listed above:

Signature:_____ Date_____

Title: _____ Phone _____

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Chronic Homeless Self-Statement Certification

I certify that I was homeless (that is sleeping in a place not meant for human habitation/living on the streets) **OR** living in a homeless emergency shelter during the following period(s) of time **(Maximum of 3 months)**:

Date_____/_____/_____, I lived at _____

Date_____/_____/_____, I lived at _____

Date_____/_____/_____, I lived at _____

What else would you like to share about your history? For example, *"I can't remember the name of the place where I was living during the fall of 2004 but I believe that it was a homeless 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)

I reviewed the above statement with the client.

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

Intake Worker: What steps were taken to verify this information? _____

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Permanent Supportive Housing
Certification of Disability for Program Eligibility Purposes

(form to be completed by a licensed professional, certified to treat the condition listed below)

RE: _____

(Name of Applicant/Resident)

I authorize the release of information, relative to my physical or mental impairment, to _____to verify whether my disability is covered by the definitions below. This information will be used to verify my eligibility for the housing program.

Client Signature: _____Date: _____

The individual named above is an individual with **(Check appropriate box(es) if the Professional has diagnosed and is currently treating the specific Disability)**:
Regulations in H.E.A.R.T.H. Act require that the disability must always be specifically identified in order to be able to confirm eligibility.

☐ Mental Disability (Serious mental illness) _____

☐ Chronic Physical Illness or Disability_____

☐ Developmental Disability _____

☐ Substance Use Disorder _____

☐ Post-Traumatic Stress Disorder_____

☐ Cognitive impairments resulting from brain injury_____

In my professional opinion, the applicant meets the definition of a Disabled Person, as defined above.

_____ _____
Signature Date

_____ _____
Printed Name Phone Number

_____ _____
Professional Title Email

_____
Address City State Zip

(Please complete back of form)

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Permanent Supportive Housing
Certification of Disability for Program Eligibility Purposes

The definition of a disabled person includes a person who meets any <u>one</u> of the following criteria:

The term homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has a disability that:

☐ *Is expected to be long-continuing or of indefinite duration;*

I. Substantially impedes the individual's ability to live independently;
II. Could be improved by the provision of more suitable housing conditions; and
III. Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

☐ *Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or*

☐ *Is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.*

In my professional opinion, the applicant meets the definition of a Disabled Person, as defined above.

_____ _____
Professional Title Signature Date

_____ _____
Printed Name Phone Number

Part 4: Client Certification:

To the best of my knowledge and ability, all the information provided in this document is true and complete. I also understand that any misrepresentation or false information may result in my participation being cancelled or denied, or in termination of assistance. It is my responsibility to notify _____ of any changes in my housing status or address in writing during program participation and I understand that my application may be cancelled if I fail to do so.

Client Name: (Printed)	**Client Signature:**	**Date:**

Staff Certification:

To the best of my knowledge and ability, all of the information and documentation used in making this eligibility determination is true and complete.

Staff Name: (Printed)	**Staff Signature:**	**Date:**
Staff Role:	**Agency:**	

Notes: