

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 Monday 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*)



Pathways to Home Helpful Hints

The HMIS CES team understands that submitting documentation for case conference or housing matches can be a daunting task. Below is a list of helpful hints to address common errors found during the documentation review process. Please review and pay special attention to these areas to help increase the accuracy of documents submitted and to avoid delays in scheduling clients for case conference or matching to available housing opportunities.

Always review all documentation for accuracy and completion PRIOR to submittal.

- Ensure documents are filled out completely—submit the most current version, leave no blanks, and include specific details regarding the client’s status and vulnerabilities
- All documents must be submitted under the eligible person’s full legal name and match across all the documents and in HMIS
- HMIS is a great resource for verification if client is enrolled in a Street Outreach, Emergency Shelter, or Safe Haven program. Drop-in services cannot be used to verify homelessness
- Include a PDF “printout” from the Entry/Exit tab (not Service Transactions) when using HMIS to verify homelessness
- Check that the correct form is being used for the type of verification being reported, and that it matches the verification type that is selected on the Housing History form
- Submit an At-Risk tool instead of a VAT for clients at imminent risk of homelessness
- Enter a specific month/day/year for each date being verified (*date ranges such as June-November 2024 are not acceptable*)
- Use the Third-Party Verification form to describe in detail where the client has been witnessed homeless
- If a client submits a Self-Statement of Homelessness, always fill out the bottom of that form detailing how you verified the client’s statement (this is a HUD requirement)
- Ensure you are submitting no more than three months TOTAL of client Self-Certification, Outside Provider Verification, or a combination of both
- Always enter the client in CES and run an eligibility module at time of document submission
- When sending files through the document submission portal, select the document files while in the portal window to attach them rather than using a “drag-and-drop” method. If not attached directly, these documents will not populate on our end.

We recognize that these helpful hints do not encompass all potential errors that may be found during the documentation review process and encourage all case workers to thoroughly review their documentation to ensure completeness prior to submitting documentation. Case Workers will be asked to correct any documentation found to have errors or missing information during the documentation review process with support from the HMIS CES team.

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)

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.

| | |
|-----------------------------|---|
| Client Name: | Date of Birth: |
| Number in Household: | Client Head of Household: <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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 | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets | <input type="checkbox"/> Streets |
| <i>Check all that Apply</i> | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter | <input type="checkbox"/> Shelter |
| | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Safe Haven |
| | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) | <input type="checkbox"/> Inst. (<90 days) |
| | Doc. Type | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation | Third party observation |
| <i>Check One (Except Self-Cert. select both)</i> | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS | <input type="checkbox"/> HMIS |
| | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager | <input type="checkbox"/> Obsv. Outreach wrkr/case manager |
| | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker | <input type="checkbox"/> Obsv. by Comm. worker |
| | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. | <input type="checkbox"/> Self-Cert. |
| | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral | <input type="checkbox"/> Referral |
| | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks | Breaks |
| | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork | <input type="checkbox"/> Discharge Paperwork |
| Doc. Att. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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? * <input type="checkbox"/> Yes <input type="checkbox"/> No <i>* 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 your project administrator to ensure your project has not exceeded its self-certification cap.</i> |
| Key | Mo. = Month, Yr. = Year, Inst. = Institution, Doc. = Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description |

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: _____

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 _____

**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)

**Permanent Supportive Housing
Certification of Disability for Program Eligibility Purposes**

The definition of a disabled person includes a person who meets any one 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: