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, revised with your agency's letterhead 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 medical professional who is licensed to diagnose and treat 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.
- ☐ (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 are:

- A homeless person having a disability
- A person who lives in an emergency shelter, a safe haven or a place not meant for human habitation AND has been homeless (as described above) continuously for at least 12 months or on at least four separate occasions lasting longer than 7 nights
- An individual residing in an institutional care facility for less than 90 days (including jail, substance abuse or mental health treatment facility, hospital, or similar facility) who met all the criteria for this definition before entering that facility
- A family with an adult (or a minor if no adult) head of household who meets all the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless. Families who have at least one adult member meeting this description who would also be considered chronically homeless.

(NOTE: A "break" in homelessness is 7 or more nights. An individual residing in an institutional care facility does not constitute a break in homelessness.)

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SUPPORTIVE DOCUMENTATION REQUIREMENTS:

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 or any other provider or community member.
- ❑ Certification Self-Statement signed by the client.
- ❑ Documentation from HMIS or similar database

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 Ventura VA Clinic 877-251-7295 to establish healthcare services or/ Salvation Army Supportive Services Veteran Families for support.
3) Yes ☐ or No ☐: The DD 214 Form is attached.
   If no, refer to Veteran Services Office 805-477-5155 to make an appointment or Gold Coast Veterans Foundation for support.

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

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

Part 1: Current Housing Status Details
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, uninhabitable garage, RV, etc.) ☐ In a Safe Haven ☐ In an Institutional Care Facility (Where they have been for fewer than 90 days) Location Name and Address: _____

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

Location Name/ Address: **Current Housing Status Notes-Describe living situation/circumstances:** *(ex: living in a garage w/out proper ventilation)*

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	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. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member	Third Party Observation ☐ HMIS ☐ Obsv. By Outreach wrkr/case mgr ☐ Obsv. By Community member
	☐ 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
Case Mgr. Review Checklist- Doc. Att.	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No	Documents Attached? ☐Yes ☐No

Break Mo./Yr. & Descr. or **N/A** If no breaks, please enter N/A	Break 1: Break 2: Break 3: If there are additional breaks please give details 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*

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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:*

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

Month 1:_____Month 2:_____

Month 3:_____Month 4:_____

Month 5:_____Month 6:_____

Month 7:_____Month 8:_____

Month 9:_____Month 10:_____

Month 11:_____Month 12:_____

Signature: _____Date: _____

Print Name: _____Date: _____

Title: _____Phone: _____

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Referral from Outside Service Provider Verification of Homeless Status

Instructions: This form can be completed by 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):*

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

Month 1:_____Month 2:_____

Month 3:_____

Signature: _____Date: _____

Print Name: _____Date: _____

Title: _____Phone: _____

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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:

Between *Example*: Oct, 2015 and *Feb., 2016* I lived at *ARCH Shelter*

Month 1:_____ I lived at_____

Month 2:_____ I lived at_____

Month 3:_____ 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)

_____

(Print Name)

I reviewed the above statement with the client.

_____ _____ _____

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

_____

(Print Name)

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

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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 all that apply and specify diagnosis)**
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)

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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

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Part 4: Staff and Client Certifications

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: