hhc
Housing & Homeless Coalition
Of Central New York

HHC of Central New York CE Chronically Homeless Documentation

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Client Name:

HMIS ID:

Requirements – Disability	Acceptable forms of Documentation
Individual MUST have a disability, defined as having one or more of: 1) Physical, mental or emotional impairment of ongoing duration 2) Developmental Disability 3) HIV/AIDS	**Check and attach documentation for all that apply:** ☐ Documentation from a licensed professional (HHC Disability verification form is best, documentation listing diagnosis and credentials of professional is OK) ☐ Documentation from SSA for persons receiving disability benefits (i.e., award letter or copy of check)

AND

Individual or family resided in an emergency shelter or place not meant for human habitation for ***one*** of the below lengths of time:

Requirements – 1 Year Continuous	Acceptable forms of Documentation
12 months continuous (single encounter in a month is sufficient to consider household homeless for entire month unless evidence of a break)	**Check and attach documentation for all that apply** *(in order of preference)***:** ☐ HMIS Entry/Exit Page ☐ Written verification from a third party (Use HHCCNY Documentation form) ☐ Written observation by intake worker (Use HHCCNY Documentation form) ☐ Written Self-certification by the individual or head of household that (s)he was living on the streets, shelter, etc. *(can only document 3 months)* (Use HHCCNY Documentation form)

OR

Requirements – 1 Year Cumulative	Acceptable forms of Documentation
At least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months (single encounter in a month is sufficient to consider household homeless for entire month unless evidence of a break)	**Check and attach documentation for all that apply** *(in order of preference)***:** ☐ HMIS Entry/Exit Page ☐ Written verification from a third party (Use HHCCNY Documentation form) ☐ Written Self-certification by the individual or head of household that (s)he was living on the streets, shelter, etc. *(can only document 3 months)* (Use HHCCNY Homeless Self-Certification form)
3 breaks constituting of at least 7 nights not residing in an emergency shelter or place not meant for human habitation (stays in institutions of fewer than 90 days do not constitute a break and count toward total time homeless**)**	**Check and attach documentation for all that apply:** ☐ Written verification from a third party ☐ Written Self-certification of breaks by the individual or head of household (Use HHCCNY breaks in homeless status self-statement certification form)

Staff Name & Title: _____ **Agency: _____**

Staff Signature: _____ Date: _____

Coordinated Entry
Verification of Disability Form

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*(**ONLY** a licensed professional with credentials to diagnose an individual may complete this form)*

_____*(Applicant's Name)* is applying for a permanent supportive housing program, as defined by the U.S. Department of Housing and Urban Development (HUD). This form is part of the eligibility process; please contact us with any questions or concerns. We are requesting your assistance in completing and returning this form as quickly as possible to:

_____

Referring/Verifying Agency Address

_____

Contact Person E-mail Phone and Fax Number

Eligible Disability Types

Please select all of the following that apply:

☐ a disability as defined in Section 223(d) of the Social Security Act as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which…has lasted or can be expected to last for a continuous period of no less than 12-months..."

☐ a physical, mental, or emotional impairment which is (a) expected to be of long-term, continued, and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions;

☐ a developmental disability as defined in Section 102(8a) of the Developmental Disabilities Assistance and Bill of Rights Act. In general, this "… means a severe, chronic disability of an individual that—is attributable to a mental or physical impairment or combination of mental and physical impairments"

☐ the disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiological agency for acquired immunodeficiency syndrome

Disability Information

Please check all that apply:

☐ Mental Health Disorder
☐ Substance Use Disorder
☐ Co-occurring Mental Health Disorder and Substance Use Disorder
☐ HIV/AIDS
☐ Physical Disability
☐ Developmental Disability

Please check appropriate credential:

☐Psychiatrist ☐Physician ☐Physician Assistant ☐Nurse Pract. ☐LCSW ☐LMHC ☐Psychologist ☐ CASAC

_____

Signature *Printed Name* *Date*

_____

Office/Practice/Agency Name *Phone Number* *License Number*

Chronically Homeless
3rd Party Verification

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Date:___/___/_____

To:

_____
_____
_____

Dear _____,

_____ (Applicant's Name) is applying for a supportive housing program as defined by the U.S. Department of Housing and Urban Development (HUD). The attached *Third-party Homelessness Verification* form is part of the eligibility process. We are requesting your assistance in completing and returning this form as quickly as possible to:

_____ _____
Referring/Verifying Agency Address

_____ _____ _____
Contact Person Email Phone/Fax Number

Please contact us with any questions or concerns,

Sincerely,

_____
Signature of Agency Representative

Client consent for release
I hereby authorize the release of the information requested in the attached Third-Party Homelessness Verification form for the purpose of verifying my eligibility for supportive housing and related services.

_____ _____
Signature of Applicant Date

** This release of information will expire one year from the date of the applicant's written or oral consent indicated above

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3rd Party Verification

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Section A: This is to be completed by the housing provider, or a case manager through shelter or street outreach collecting information on behalf of the housing provider. The housing provider or case manager should specify the periods to be verified by the third party in the blanks below and only ask for verifications for gaps not covered by HMIS or other 3rd party verification.
Housing Provider is seeking verification for the following occasions of homelessness experienced by

_____ (Applicant's Name)

(1) Between: _____/_____/_____ and: _____/____/_____

(2) Between: _____/_____/_____ and: _____/____/_____

(3) Between: _____/_____/_____ and: _____/____/_____

(4) Between: _____/_____/_____ and: _____/____/_____

Section B: This is to be completed by the third party who may verify the entire time requested by the housing provider or any smaller periods within the requested

Time Period Being Verified		Homeless Situation	Location
Start Date	End date		Address, Intersection, or Zip Code
June 22, 2015	*July 11, 2015*	*Applicant was living on the street in an encampment*	*Lakeshore Drive and Wilson Ave*

Note: HUD defines homelessness as **1)** sleeping in a place not meant for human habitation (such as living on the streets, in a car, at a park, or on public transportation) **OR 2)** living in a homeless emergency shelter. All circumstances listed above should fall into one of these 2 categories with an exception if the client is currently staying in an Institutional Care Facility where they have been for fewer than 90 days and which they entered from one of the above 3 categories.

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Chronically Homeless
3rd Party Verification

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Section C: This is to be completed by **the third party** providing the verification.

Please check your most applicable affiliation:

☐Correctional Facility	☐Mental Health Provider/Institution	☐Service Provider
☐Emergency Shelter	☐Substance Dependence Treatment Provider/Facility	☐Law Enforcement
☐Faith Based Organization	☐Transitional Housing	☐Homeless Outreach Team/Worker
☐Veteran's Organization	☐Medical Provider/Institution	☐Community Member
☐Business	☐Community Organization	☐Other _____

Please check all applicable statements

☐ I can confirm that the applicant's history of experiencing homelessness from field visits where I met with them in an emergency shelter or places not meant for human habitation.

☐ I can confirm the applicant's history of experiencing homelessness from agency records and experience of having served them throughout the time they have been homeless.

Name of Verifier: _____ Title:_____

Signature of Verifier _____Address: _____

Phone Number: _____Date:_____

Housing & Homeless Coalition
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Breaks in Homelessness
Certification

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Breaks in Homeless Status 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 breaks in their homelessness.

I certify that I was **not homeless** (that is sleeping in a place meant for human habitation such as sleeping on someone's couch) during the following period(s) of time:

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 _____

Between _____ and _____ I lived at _____

Between _____ and _____ I lived at _____

What else would you like to share about your history?

_____
_____
_____
_____
_____
_____
_____

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)

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Instructions: This 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. This Self-statement should be maintained in the client's file (of both the referring project and the project accepting the referral). Up to 3 months of an individual's 12 months of homelessness can be self-reported if no other 3rd party verification is able to be obtained.

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., 2005 and Aug., 2005 I lived at *Lifeline Shelter, Cleveland*

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 _____

Between _____ and _____ I lived at _____

What else would you like to share about your history? For example, "*I can not 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)