Bridging The Gap

VERIFICATION OF CHRONIC HOMELESSNESS

ELIGIBILITY REQUIREMENT

Where chronic homelessness is an eligibility requirement for entry into the Project, (e.g., Permanent Supportive Housing (PSH) for the chronically homeless), intake staff are required to verify chronic homelessness per the CoC interim rule, 24 CFR 578.3.

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 month 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. 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. An individual in transitional housing is NOT considered chronically homeless; even if they met the criteria prior to entering the transitional housing program. 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).

APPLICANT INFORMATION

Applicant Name:_____ Date of Birth:_____

Number in Household:_____ Client Head of Household: o YES o NO

DISABLED STATUS VERIFICATION

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;
  - Substantially impedes the individual's ability to live independently;
  - Could be improved by the provision of more suitable housing conditions; and
  - 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.

The head of household has been diagnosed with one or more of the following (check all that apply)

❑ Substance use disorder o
❑ Serious mental illness
o ❑ Developmental disability
❑ Post-traumatic stress disorder
❑ Cognitive impairments resulting from brain injury ❑ Chronic physical illness or disability
❑ Other:_____

Documentation Attached

- o Written verification from a *licensed professional* in Hawaii certifying that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently. *Attach Disability Certification form and physician certification on business letterhead.*
- o Written verification from the *Social Security Administration (SSA). Attach SSA letter.*
- o The receipt of a *disability check. Attach SSA disability check.*
- o Temporary Option – Staff observations of a disability can be used for program entry, but must be confirmed by one of the above written standards within 45-days.

Notes:

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HOMELESS HISTORY

To be considered chronically homeless, the individual must meet one of the following two homeless history conditions.
The individual must have been living in a place not meant for human habitation, an emergency shelter, or a safe haven:

o Continuously for at least 12 months, without a break of 7 or more consecutive nights

Client is currently residing: o Emergency Shelter o Place not meant for human habitation
o Safe Haven o Institutional Care Facility (Where they have been for fewer than 90 days)

Start Date:_____ End Date:_____

Location Name/Address:_____

o OR on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness included at least 7 consecutive nights not in a place not meant for human habitation, an emergency shelter or a safe haven.

Chronic Homelessness Summary

	Start Date	End Date	Duration (Mos)	Provider Name or Description	Type	Documentation	Attached
Sample Episode	*1/1/2016*	*2/1/2016*	*2*	*Rescue Mission*	o Place not meant for habitation ý Emergency Shelter o Institution<90 Days o Safe Haven	o HMIS o Observed by Outreach ý Service Provider o Discharge Paperwork o Referral o Self-Certification	ý YES o NO
Episode 1					o Place not meant for habitation o Emergency Shelter o Institution<90 Days o Safe Haven	o HMIS o Observed by Outreach o Service Provider o Discharge Paperwork o Referral o Self-Certification	o YES o NO
BREAK				o Institution >=90 Days o Other>=7 nights:_____			
Episode 2					o Place not meant for habitation o Emergency Shelter o Institution<90 Days o Safe Haven	o HMIS o Observed by Outreach o Service Provider o Discharge Paperwork o Referral o Self-Certification	o YES o NO
BREAK				o Institution >=90 Days o Other>=7 nights:_____			
Episode 3					o Place not meant for habitation o Emergency Shelter o Institution<90 Days o Safe Haven	o HMIS o Observed by Outreach o Service Provider o Discharge Paperwork o Referral o Self-Certification	o YES o NO
BREAK				o Institution >=90 Days o Other>=7 nights:_____			
Episode 4					o Place not meant for habitation o Emergency Shelter o Institution<90 Days o Safe Haven	o HMIS o Observed by Outreach o Service Provider o Discharge Paperwork o Referral o Self-Certification	o YES o NO

Total Months:_____(transfer this number to A below)

Result of Chronic Homelessness Summary

A. Total # of months in a place not meant for human habitation or an emergency shelter:_____. (From above chart, must be at least 12)
B. Time and Episodes in a place not meant for human habitation or an emergency shelter: o Continuously for 12+ Months o At least 4 times in last 3 Years.
C. Of Total Months, how much was documented by Third Party documentation:_____By Self-Certification_____Self Cert must be < 3 months
D. If the individual meets the above criteria they meet the homeless history criteria for Chronic Homelessness.
E. Attach additional page if necessary

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 of 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.

Name _____ Signature _____ Date _____

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

Name/Title of Person Completing Form _____ Signature _____ Date _____

Name of Supervisor/Title of Person Reviewing this Form _____ Signature _____ Date _____

*Supervisor must verify supporting documents and completeness of this form prior to consideration of housing prioritization and program entry selection.