

## 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 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

<b>Client Name:</b>	<b>Date of Birth:</b>
<b>Number in Household:</b>	<b>Client Head of Household:</b> <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)

<b>Start Date:</b> _____	<b>End Date:</b> _____
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**Location Name/Address:**

**Current Housing Status Notes:**



	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"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)	<input type="checkbox"/> Streets <input type="checkbox"/> Shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Inst. (<90 days)
Doc. Type	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence	<input type="checkbox"/> HMIS <input type="checkbox"/> Obsv. By Outreach <input type="checkbox"/> Comp. Database <input type="checkbox"/> Discharge Paperwork <input type="checkbox"/> Referral <input type="checkbox"/> Self-Cert. <input type="checkbox"/> Staff Doc. of Situation <input type="checkbox"/> Doc. of steps to obtain evidence
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 <b>YES</b>, 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. <b>Please check with you project administrator to ensure your project has not exceeded its self-certification cap.</b></i>
Key	<i>Mo. = Month, Yr. = Year, Inst. = Institution, Doc. = Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description</i>



## Third Party Verification of Homeless Status

**Instructions:** This recommended template can be copied onto letterhead or recreated with the similar content and printed on letterhead. This form can be completed by an outreach work, social service provider, healthcare provider, law enforcement officer or other qualified person who can verify the client's homeless status. A letter or email from a provider is also acceptable documentation.

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:

between: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ and: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

between: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ and : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

between: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ and : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

between: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ and : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please specify where the client has been living and your relationship to the client:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_



## 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	<u>Example: Oct, 2015</u>	and	<u>Feb., 2016</u>	I lived at	<u>Oxnard Shelter</u>
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’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)

## 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

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Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**The definition of a disabled person includes a person who meets any one of the following criteria:**

Developmental disability means, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002) **(Check all that apply):**

- (1) A severe, chronic disability of an individual that—
  - (i) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
  - (ii) Is manifested before the individual attains age 22;
  - (iii) Is likely to continue indefinitely;
  - (iv) Results in substantial functional limitations in three or more of the following areas of major life activities:
    - (A) Self-care;
    - (B) Receptive and expressive language;
    - (C) Learning;
    - (D) Mobility;
    - (E) Self-direction;
    - (F) Capacity for independent living;
    - (G) Economic self-sufficiency; and
  - (v) Reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
  
- (2) An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in paragraphs (1)(i) through (v) of the definition of “developmental disability” in this section if the individual, without services and supports, has a high probability of meeting those criteria later in life.

Disability means:

- (1) A condition that:
  - (i) Is expected to be long-continuing or of indefinite duration;
  - (ii) Substantially impedes the individual’s ability to live independently;
  - (iii) Could be improved by the provision of more suitable housing conditions; and
  - (iv) Is a physical, mental, or emotional impairment, including impairment caused by alcohol or drug abuse, post- traumatic stress disorder, or brain injury;
  
- (2) A developmental disability, as defined in this section.
  
- (3) A person whose sole impairment is alcoholism or drug addiction.





## 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:**