HUD CHRONIC HOMELESSNESS - VERIFICATION PACKET

Client Name: ______________________________ Client DOB: ___________ Date Completed: ____________

There are several steps to verifying that someone meets the HUD definition for chronic homelessness*. This worksheet will guide you through those steps. Please follow along below. If you get stuck see the quick reference on page 3.

*Remember – “Homeless” below means living in a place not meant for human habitation, in an emergency shelter/motel voucher program or a safe haven. Individuals in transitional housing are not considered chronically homeless but do meet the definition of “homeless” for other HUD and non-HUD programs.

Section 1: Current Living Situation

1) Is this individual currently homeless, living in an institutional living setting, or in a rapid re-housing program? Institutional living includes inpatient treatment, acute care facilities like hospitals and skilled nursing, and criminal justice institutions. □ Yes □ No

● If no, STOP, this individually is not chronically homeless.

● If the individual is currently homeless, GO to Section 2.

   a) If the individual is living in an institutional setting, have they been there less than 90 days and were they homeless upon entry to the institutional setting? □ Yes □ No

   b) If the individual is enrolled in a rapid re-housing program, have they been in the program for less than 24 months and were they homeless upon entry to the program? □ Yes □ No

● If no to both a and b, STOP, this individually is not chronically homeless.

Section 2: Disability Verification

Does this individual have a diagnosed and documented health condition expected to be of long-continued and indefinite duration AND substantially impedes their ability to live independently AND is of such a nature that the ability to live independently could be improved by more suitable housing conditions? □ Yes □ No

● If this person does not have a disability, STOP, this individually is not chronically homeless.

Section 3: Duration of Homelessness

Has this individual been homeless for at least one year continuously; OR have they experienced at least four separate homeless occasions over 3 years with a break of at least 7 days between each occasion; AND does the total amount of time homeless in the last three years add up to at least 12 months? Use the housing history chart on the next page to guide your response. □ Yes □ No

● If no, STOP, this individually is not chronically homeless.

● If yes, this individual is chronically homeless. Continue to Section 4.
Section 4: Documenting Chronic Homelessness

Now it is time to gather documentation to verify chronic homelessness. HUD requires the following documentation:

a. Evidence of current homeless status; AND
b. Evidence of the duration of homelessness
   i. Evidence that the current homeless occasion has been continuous, for at least one year; OR
   ii. Evidence that the household experienced at least four separate homeless occasions over 3 years with a break of at least 7 days between each episode; AND the total amount of time homeless in the last three years is at least 12 months

B. To document verification of disability a licensed health care professional, who can diagnose and treat the condition being verified, needs to complete the Verification of Disability form that can be found on the last page of this packet.

If you have questions, contact Home Stretch at HomeStretch@acgov.org or (510) 567-8017.
To access additional forms and information about Home Stretch, visit http://everyonehome.org/our-work/home-stretch/.
# HUD Homeless Definition Living Situation Quick Reference

<table>
<thead>
<tr>
<th>Applicant's Current Living Situation</th>
<th>Is applicant considered Literally Homeless in this housing?</th>
<th>Is the applicant considered currently homeless for CH purposes?</th>
<th>Does time in this housing count as time homeless for CH purposes?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Place not meant for human habitation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Transitional Housing (TH)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>A stay in TH of 7 days or more is considered a break in homelessness. Only programs publicly funded as transitional housing fit this category.</td>
</tr>
<tr>
<td>Rapid Rehousing (RRH)</td>
<td>Yes*</td>
<td>Yes*</td>
<td>No</td>
<td>*If less than 24 months in RRH and the person was literally homeless upon program entry.</td>
</tr>
</tbody>
</table>

## Institutional Living Setting
(Examples: acute medical facility, inpatient substance use or mental health treatment, crisis residential, hospital, jail)

<table>
<thead>
<tr>
<th>Less than 90 days</th>
<th>Yes, if the person was literally homeless upon program entry.</th>
<th>Yes, if the person was literally homeless upon program entry.</th>
<th>Yes, if the person was literally homeless upon program entry.</th>
<th>Stays in institutions of 90 days or more constitute a break in homelessness and do not count toward total time homeless.</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 90 days</td>
<td>No</td>
<td>No</td>
<td>No</td>
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</tr>
</tbody>
</table>

## Hotel/Motel

<table>
<thead>
<tr>
<th>Paid for by agency/voucher</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>If the hotel is paid for by an agency to divert the person from shelter or the streets, they retain homeless status.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid for by applicant, relatives, friends or others (7+ nights)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>If the hotel stay is less than 7 consecutive nights the person retains their homeless status.</td>
</tr>
</tbody>
</table>

## Staying with Friends or Family/Couch Surfing

<table>
<thead>
<tr>
<th>Less than 7 consecutive nights</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Seven (7) or more consecutive nights</td>
<td>No</td>
<td>No</td>
<td>No</td>
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</table>

## Other

<table>
<thead>
<tr>
<th>Sober Living</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>Transitional residential and limited-term recovery programs are institutional living.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board and Care</td>
<td>No</td>
<td>No</td>
<td>No</td>
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</table>

*Revised 10/25/19

Housing History Chart  
(for tracking documentation needed)

<table>
<thead>
<tr>
<th>Locations over the last three years, starting with the present. Please include street(s) and city. Verification beyond 12 months is not needed for individuals who have been continuously homeless for the past 12 months.</th>
<th>Type of Living Situation</th>
<th>Start Date</th>
<th>End Date</th>
<th>Total Months</th>
<th>Verification Available From?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter (ES), Place Not Meant for Habitation (PNMH), Transitional Housing (TH), Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), Institution (INST), Not Homeless (NH)</td>
<td>□ ES □ PNMH □ TH □ PSH □ RRH □ INST □ NH</td>
<td></td>
<td></td>
<td></td>
<td>□ HMIS □ Professional Assessment □ Witness □ Self-Certification □ NH</td>
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<td></td>
<td>□ ES □ PNMH □ TH □ PSH □ RRH □ INST □ NH</td>
<td></td>
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(Revised 10/25/19)  
***IMPORTANT, PLEASE READ***
Please provide verification of homelessness on your agency letterhead. The recommended template below may be copied onto letterhead or recreated with the same content and printed on letterhead.

Professional Assessment of Living Situation

This form should be utilized to verify homelessness for months in which a service provider, acting in their official capacity, had an encounter with a client and, based on their knowledge and professional opinion, believe that the individual or head of household was living in a place not meant for human habitation, an emergency shelter, or a safe haven at the time of the encounter. The service provider may have physically observed the individual living in a place that is consistent with the HUD definition of literal homelessness or they may have had an encounter in another setting and during that encounter there was evidence that led the service provider to conclude that the individual was living in a situation consistent with the HUD definition of literal homelessness. One encounter within a month is sufficient to verify homelessness for the entire calendar month. Service providers include outreach workers, housing navigator, healthcare professionals, members of law enforcement, and case managers. For each location that you can verify the applicant was living, complete all information requested. At least one observation per month is required by HUD.

Applicant Name: ___________________________________ Date of Birth: ______________

For each location in which the applicant was living, complete all information requested.

<table>
<thead>
<tr>
<th>Location of encounter (encampment location, cross streets, name of clinic, address, office location, etc.):</th>
<th>Statement detailing the aspects of the interaction that indicated the Applicant was experiencing homelessness at the time of the encounter (physical observation of the Applicant’s living situation, Applicant explained their living situation, Applicant was carrying their belongings with them, Applicant seemed stressed about their living situation, etc.):</th>
<th>Presumed location Applicant was living (address, name of public space, street name, landmark, etc.):</th>
<th>Presumed living situation of Applicant (in car, in a tent, on the street, in emergency shelter etc.):</th>
<th>Date of encounter: (MM/DD/YYYY)</th>
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I certify that information described above is accurate and that, based on my professional opinion, the applicant was experiencing homelessness at the time of the encounter(s).

Printed Name: ___________________________ Organization: ___________________________ Title/Role: ___________________________

Signature: ___________________________ Date: ___________ Phone: ___________ Email: ___________

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***IMPORTANT, PLEASE READ***

Please provide verification of homelessness on your agency letterhead. The recommended template below may be copied onto letterhead or recreated with the same content and printed on letterhead.

Summary of Witness Statement

This form should be utilized by a service provider to verify homelessness for months in which a community member, such as a shopkeeper or neighborhood resident, physically observed an individual or head of household living in a place not meant for human habitation and provided an oral or written description of their observations to the service provider. The community member must indicate which approximate dates they observed the individual or head of household residing in a place not meant for human habitation and the location. The service provider must use their professional judgement to determine if the source is reliable. For each location in which the applicant was observed to be living, complete all information requested. At least one observation per month is required by HUD.

-------------------------COPY SECTION BELOW ON TO AGENCY LETTERHEAD OR USE SIMILAR TEXT ON AGENCY LETTERHEAD------------------

Applicant Name: ___________________________ Date of Birth: ___________

Community Member Name: __________________ Relation to Applicant: ___________

Phone Number (if available): ___________

For each location in which the community member observed the Applicant living, complete all information requested.

<table>
<thead>
<tr>
<th>Location (address, name of public space, street name, landmark, etc.):</th>
<th>Description of living conditions observed (sleeping in a car, in a tent, in the open, etc.):</th>
<th>Date observed:</th>
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I certify that the information above was reported to me by the listed community member and I believe it to be an accurate account.

______________________________________________  ______________________________  __________________________
Printed Name  Organization  Title/Role

Signature  Date  Phone  Email

(Revised 10/25/19)

Homelessness Self Certification Statement

Instructions: This form may be used when an applicant lacked connections with service providers to complete a third-party verification of homelessness during a time period for which homelessness must be verified. Service providers must document all attempts to obtain third party verification for each self-certification (see below).

Applicant Name: ______________________ Date of Birth: __________ Phone or E-mail: __________________________

I certify that I have been homeless during the following periods of time and in the following locations.

<table>
<thead>
<tr>
<th>Location (address, name of public space, street name, landmark, etc.):</th>
<th>Description of living conditions (sleeping in a car, in a tent, in the open, etc.):</th>
<th>Start date:</th>
<th>End date:</th>
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What else would you like to share about your homeless status during the period of time referenced above (optional)? For example, “I cannot remember the name of the place where I was living during the fall of 2018 but I believe it was an 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 of Signature: __________

Staff Section: DO NOT SKIP THIS STEP

Please document all attempts to obtain 3rd party verification for the period of homelessness documented above.

1) ______________________________________________________________________________________

2) ______________________________________________________________________________________

3) ______________________________________________________________________________________

I reviewed the above statement with the applicant and certify that the attempts to obtain third-party verification are accurate.

Name of Staff (Print): ______________________

Staff Member Organization and Title: ______________________ Staff Phone Number: __________

Signature of Staff: ______________________ Date of Signature: __________

Guide to Home Stretch Disability Verification

Instructions: Use this information as a guide when documenting disability for a Home Stretch referral. Include appropriate disability verification to enable matching to specific housing opportunities.

According to HUD guidelines, a person shall be considered to have a disabling condition if such a person has a diagnosable:

- Substance use disorder; AND/OR
- Serious mental illness; AND/OR
- Development disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000, (42 U.S.C. 15002); AND/OR
- Post-traumatic stress disorder (PTSD); AND/OR
- Cognitive impairments resulting from brain injury; AND/OR
- Chronic physical illness or disability (e.g. HIV/AIDS)

And that condition meets all of the criteria below:

- Is expected to be of long-continued and indefinite duration; AND
- Substantially impedes the person’s ability to live independently; AND
- Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.

There are specific housing opportunities with set-asides or preferences for people with the following health conditions: HIV/AIDS, serious mental illness, developmental disabilities, and substance use conditions. Please have a licensed health care professional complete the Home Stretch Disability Verification to be considered for these specific housing opportunities.

If a licensed health care professional CANNOT complete the disability verification, then disability can also be verified by providing one of the documents listed below. However, it is strongly recommended that the Home Stretch Disability Verification be completed if possible.

Disability can also be verified by providing one of the documents listed below:

- Written verification of disability from the Social Security Administration, OR
- Copy of a disability check (e.g., Social Security Disability Insurance check or Veteran’s Disability Compensation)
Home Stretch Disability Verification
To Be Completed By A Licensed Health Care Professional

This verification will help prioritize homeless and disabled individuals for permanent supportive housing opportunities in Alameda County.

This Disability Verification Form is for:
Patient Name: ____________________________________________________________
Patient Date of Birth: ______________________________________________________

Clinician Contact Information:
Organization Name (if applicable): __________________________________________
Address: __________________________________________________________________
Phone #: __________________________________________________________________
E-mail: __________________________________________________________________

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of patients. Within my scope of practice, I have determined that the patient named above has the following diagnosable condition(s) that are: 1) expected to be of long-continued and indefinite duration; AND 2) substantially impedes the individual’s ability to live independently; AND 3) The condition could be improved by more suitable housing conditions. (check ALL that apply):

☐ Substance use disorder**
☐ Serious mental illness, including severe Post Traumatic Stress Disorder (as defined in the DSM and is severe in degree and persistent in duration; is NOT a substance use disorder, developmental disorder, or acquired traumatic brain injury)**
☐ Developmental disability (as defined in Section 102 of the Development Disabilities Assistance Bill of Rights Act of 2000, {42 U.S.C. 15002})**
☐ Cognitive impairments resulting from brain injury**
☐ Chronic physical illness or disability*
☐ HIV infection or AIDS*

*Acceptable Credentials for Medical Conditions: MD (Medical Doctor), NP (Nurse Practitioner)
**Acceptable Credentials for Mental Health & Substance Use Conditions: MD (Medical Doctor), NP (Nurse Practitioner), PsyD/ PhD (Psychologist), LCSW (Licensed Clinical Social Worker), MFT/LMFT (Marriage and Family Therapist), LPCC (Licensed Professional Clinical Counselor)

My signature below indicates my verification of the above information for this patient.
Intern Name, if applicable (printed): __________________________________________
Signature: ___________________________ Date: ________________________________

Licensed Staff Name (printed): ________________________________________________
Signature: ___________________________ Date: ________________________________
Professional License Type: ___________________________ License #: ____________

(Revised 10/25/19)