Chronic Homelessness Documentation Checklist

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

Current Housing Status
Client must currently be in one of these locations in order to be considered chronically homeless. **Client is currently residing:** ☐ In Emergency Shelter ☐ On the Streets/Place not Meant for Human Habitation ☐ In the Safe Haven ☐ In an Institutional Care Facility (Where they have been for fewer than 90 days)

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

Location Name/Address:
Current Housing Status Notes:

Chronic Homelessness Documentation Checklist

Homeless History

Starting with the most recent occasion of homelessness, provide the names, dates and types of locations and length of each stay, where the participant resided during the last three years.

- *Occasions can include more than one location*
- *A break in homelessness: At least 7 nights in which the individual did not meet the HUD homeless definition.*
- *Unless there is evidence of a break in homelessness of 7 or more nights, documentation of an encounter with a service provider on a single day within 1 month, counts for the entire month.*
- *Documentation of a break in homelessness is **not** required*

Program Name or Location	Program/Location Type	Start Date	End Date	Documentation Y/N	Doc. Type
To qualify a participant as chronically homeless, you must document at least 12 consecutive months or at least 4 separate occasions totaling 12 months within the last three years of living in a qualified location.			**TOTAL # OCCASIONS:**		
			TOTAL # MONTHS:		

Chronic Homelessness Documentation Checklist

Disability Status

• *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;*
Or
• *Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000*
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 ☐ Serious mental illness ☐ Developmental disability ☐ Post-traumatic stress disorder ☐ Cognitive impairments resulting from brain injury ☐ Chronic physical illness or disability ☐ Other:
Documentation Attached: ☐ Written verification of the disability from a licensed professional; ☐ Written verification from the Social Security Administration; ☐ The receipt of a disability check; or ☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Chronic Homelessness Documentation Checklist

Statement of Self-Certification

Instructions: The Self Certification is to be used in conjunction with third party certification (optional) or written documentation of steps taken by the intake worker to obtain other evidence of homeless history.

In the table below, list the time period and location of your living situations starting with the most recent homeless experience and working backward over the last three year.

Time Period (month/year to month/year)	Location

What else would you like to share about your history?

Chronic Homelessness Documentation Checklist

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:

Attach all supporting documentation to this verification form and secure to client file