Chronic Homeless Verification (CHV)

Defining Chronicity & Documenting Time Accumulation

Defining Chronic Homelessness

To be considered chronically homeless, an individual or adult head of household must meet the following criteria:

- They are recorded with a disability,

They have lived in a shelter, safe haven, or place not meant for human habitation for:

- 12 consecutive months with no identified breaks in homelessness, or

They are episodically homeless and have experienced:

- 4 separate occasions of homelessness in the last 3 years totalling 12 months

What constitutes a “break” in homelessness?

Occasions that are separated by a gap of time where a person has stayed at least seven nights **not living** in a shelter, safe haven, or place not meant for human habitation.

TIME ACCUMULATION WORKSHEET

Worksheet Key

Location Type	**ES** Emergency Shelter **SH** Safe Haven **H/M** Hotel / Motel paid for by program **ST** Streets / Place not meant for human habitation **IN** Institution for less than 90 days **BR** Break from literal homelessness for 7 nights or more
Method of Verification	**HMIS** HMIS Record **3rd** Third Party Verification* **Self** Self Certification* **Staff** Staff Certification

Date of Completion: _____/_____/_____

# of Months Verified Homeless	Actual Time Period being documented	Location of homeless episode or break	Location Type - Write in *only* one (see worksheet key)	Method of Verification - *only* one (see worksheet key)
0	12/23/2020 - 1/15/2021	Staying with family	BR	Self
0	12/16/2020 - 12/23/2020	Stayed in Ohia Hotel in Waikiki	BR	Self*

Verification types & order of priority

- **3rd party verification**: Documentation that comes directly from an institution such as a Hospital, Correctional Facility, etc. (must include length of stay)

- **Staff Certifications**: To be completed by the designated provider who has encountered the homeless person via Time Accumulation Worksheet (if applicable, should also be captured in HMIS).

- **Self Certifications**: Self reports can be accepted by the homeless person on unique occasions when 3rd party evidence cannot be obtained.
    - 100% of households (HH's) can self certify up to 3 months of their 12 months of homelessness.

3rd party: Institutions of care

Stays in institutional care facilities for less than 90 days do not constitute as a break in a person's homelessness, and should be included in the 12 month total time accumulation, if:

- The individual was living or residing in a place **not meant** for habitation **before** entering the facility

TIME ACCUMULATION WORKSHEET	
Worksheet Key	
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2	1/16/2021 - 2/7/2021	Times Square	ST	HMIS
0	12/23/2020 - 1/15/2021	Staying with family	BR	Self
1	11/15/2020 - 12/15/2020	Substance Abuse Treatment (30 days)	IN	3rd*

Staff Certification

TIME ACCUMULATION WORKSHEET	
Worksheet Key	
Location Type	**ES** Emergency Shelter **SH** Safe Haven **H/M** Hotel / Motel paid for by program **ST** Streets / Place not meant for human habitation **IN** Institution for less than 90 days **BR** Break from literal homelessness for 7 nights or more
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2	1/16/2021 - 2/7/2021	Times Square	ST	HMIS
0	12/23/2020 - 1/15/2021	Staying with family	BR	Self
1	11/15/2020 - 12/15/2020	Substance Abuse Treatment (30 days)	IN	3rd*
7	04/05/2020 - 11/15/2020	Sacred Ground Emergency Food Pantry	ST	Staff

Self Certification

TIME ACCUMULATION WORKSHEET	
Worksheet Key	
Location Type	**ES** Emergency Shelter **SH** Safe Haven **H/M** Hotel / Motel paid for by program **ST** Streets / Place not meant for human habitation **IN** Institution for less than 90 days **BR** Break from literal homelessness for 7 nights or more
Method of Verification	**HMIS** HMIS Record **3rd** Third Party Verification* **Self** Self Certification* **Staff** Staff Certification

Date of Completion: ____/____/____

# of Months Verified Homeless	Actual Time Period being documented	Location of homeless episode or break	Location Type - Write in *only* one (see worksheet key)	Method of Verification - *only* one (see worksheet key)
2	1/16/2021 - 2/7/2021	Times Square	ST	HMIS
0	12/23/2020 - 1/15/2021	Staying with family	BR	Self
1	11/15/2020 - 12/15/2020	Substance Abuse Treatment (30 days)	IN	3rd*
7	04/05/2020 - 11/15/2020	Sacred Ground Emergency Food Pantry	ST	Staff
2	02/05/2020 - 04/05/2020	Self Certification (Central Park)	ST	Self*

3rd Party Verification (Supplemental Forms)

*Make copies to distribute to each third party contacted for verification

THIRD PARTY VERIFICATION
SECTION A
TO BE COMPLETED BY THE HOUSING PROVIDER

The housing provider 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 methods of verification.**

HOUSING PROVIDER OF RECORD (Provider of Record) is seeking verification for the following occasions of homelessness experienced by HOMELESS CLIENT (Applicant's Name). Please specify the month and year you encountered the client while they were experiencing homelessness. One encounter in a given month is sufficient to verify a client's homelessness for the entire month (Ex. *June/2021*).

1. November /2020
2. December /2020
3. ____/____
4. ____/____
5. ____/____
6. ____/____
7. ____/____
8. ____/____
9. ____/____
10. ____/____
11. ____/____
12. ____/____

Please check the most applicable affiliation of the third party:

- ❑ Correctional Facility
- ❑ Emergency Shelter
- ❑ Faith Based Organization
- ❑ Veteran's Organization
- ❑ Business
- ❑ Mental Health Provider/Institution
- ■ Substance Dependent Treatment Provider/ Facility
- ❑ Homeless Outreach Team/Worker
- ❑ Medical Provider/Institution
- ❑ Community Organization
- ❑ Service Provider
- ❑ Law Enforcement
- ❑ Transitional Housing
- ❑ Community Member
- ❑ Other: ________

THIRD PARTY VERIFICATION
SECTION B
TO BE COMPLETED BY THE THIRD PARTY

I certify that I encountered HOMELESS CLIENT (Applicant's Name) while they were living in a homeless situation on at least one occasion in each month listed above. Please select one or more of the following statements:

- ■ I can confirm the applicant's history of experiencing homelessness from direct encounters where I observed them living in an emergency shelter, places not meant for habitation, and/or at a safe haven.
- ■ 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: SUBSTANCE ABUSE TREATMENT CENTER PROVIDER

Agency: SATC Unlimited Title: Substance Abuse Counselor

Signature of Verifier: Counselor's Signature Address: 808 Sobriety Lane

Phone Number: (808) 888-0000 Date: ________

Disability Status & Verification

What defines a disability?

A. Is expected to be long-continuing or of indefinite duration;
B. Substantially impedes the individual's ability to live independently;
C. Could be improved by the provision of more suitable housing conditions; and
D. Is a physical, mental, or emotional impairment, including an impairment caused by substance use, post-traumatic stress disorder, or brain injury.

Additional Considerations

I. Developmental Disabilities Assistance and Bill of Rights Act of 2000
II. HIV/AIDS (See HUD Final Rule) Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining Chronically Homeless Final Rule - HUD Exchange

How can providers verify disability?

3rd Party Verification (Attach this documentation to CHV Packet) See pages 9-10 of Appendix

- Written verification of disability from a licensed professional
- Verification obtained from SSA/VA
- Receipt of Disability Check
- *Intake staff-recorded observation of disability