O'ahu Continuum of Care
Chronic Homelessness Verification Packet

Chronically Homeless Definition

1. An individual is defined by the U.S. Department of Housing and Urban Development (HUD) as "Chronically Homeless" if they meet all of the following criteria:
    a. Have a disability
    b. Have lived in a shelter, safe haven, or place not meant for human habitation for:
        i. 12 continuous months with no breaks or
        ii. 4 separate occasions in the last three years that total 12 months.
            1. Each break in homelessness separating the occasions of homelessness may include at least seven nights not living in a shelter, safe haven or place not meant for human habitation
            2. Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility.
2. An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult head of household who meets all of the criteria in paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Documenting Chronic Homelessness

Per HUD Policy, recipients must seek documentation in the order below. This means that ideally, all documentation would be obtained first through third-party verification, then intake worker observations, and lastly through self-report if neither of the other sources are available.

1. Third Party Verification
    a. Third Party Certification of Homelessness Form
    b. Documentation directly from an institution such as a Hospital, Correctional Facility, etc. These forms of documentation must include length of stay.
    c. Documentation from HMIS. Must include dates of program entry & exit. Please note, an answer "Yes" to the question as to whether the individual is chronically homeless under 'Living Situation' is not sufficient.
2. Staff Certification
    a. Staff Certification of Homelessness: Completed in the Time Accumulation Worksheet (pg. 3)
3. Self-Certification
    a. Self-Certification of Homelessness Form (appendix pg 12): In extremely rare circumstances, a self-report may be accepted for the entire period of homelessness when third-party evidence cannot be obtained. When such cases present, the intake worker must obtain a certification from the individual or head of household seeking assistance, and document all efforts made to obtain third-party documentation (see 'Due Diligence Form' in appendix pg 11).
    b. 100% of households are permitted to use self-certification for 3 months of their 12 months of homelessness.

Chronic Homelessness Verification Packet

Complete sections 1-4 below. Attach supplemental forms if indicated throughout these 4 sections. Example forms may be found in the appendix.

Section 1 : Demographics

Applicant Name (First and Last): _____ Applicant DOB: _____/_____/_____

HMIS ID (include multiple IDs if applicable): _____ Applicant Contact Number: _____

- ❑ Applicant is a single adult who is at least 18 years old at the time of application (individual) OR
- ❑ Applicant is the Head of Household (family)

Section 2: Intake Worker Contact Information

Case Manager Name (First and Last): _____

Agency Name: _____ Phone Number: _____

Email: _____

Section 3: Housing History

In order to qualify for Chronic Homelessness Status, a person must have:
(A) been continuously homeless for the last 12 months OR
(B) have a minimum of 4 occasions of homelessness over the past 3 years, totaling a minimum of 12 months.

Time Accumulation Worksheet Instructions:

1. Begin documenting the household's homeless history from their current location backwards until either 12 continuous months or four episodes in three years totaling 12 months has been documented.
2. Only separate periods of literal homelessness if the method of verification changes. Do not add multiple methods of verification for the same period of time.
3. Record breaks in homelessness on separate lines.
    - Periods of literal homelessness are broken up by “breaks”. A break is determined by the person having been in a place meant for human habitation (a friend’s couch, a hotel room, etc...) for a period of at least 7 nights OR in an institutional setting for a period of more than 90 days.
    - Breaks may be documented entirely from self-certification.
    - Stays in places meant for human habitation for less than 7 nights and/or institutional settings for less than 90 days do not count as breaks and can be counted toward the applicant’s homeless time accumulation.
    - A single encounter in a month is sufficient to consider the household as experiencing homelessness for the entire month unless there is clear evidence of a break.
4. Once the above steps are completed, check the applicable box at the bottom of the worksheet.
5. If selecting third party verification or self certification as the method of verification, include additional forms to supplement the Time Accumulation Worksheet. Example forms may be found in the Appendix.

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
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)
			(Select One)	(Select One)

If household has experienced 12 continuous months of literal homelessness with no breaks, check the box below: ☐

If the household has experienced a minimum of 4 episodes of literal homelessness within a 3 year period totaling 12 months or more, check the box below: ☐

*If using third party verification or self certification as the method of verification for periods of time literally homeless, include additional forms found in the Appendix.

Section 4: Disability Status

I. A person shall be considered to have a disability if he or she has a disability that:
   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.

II. A person will also be considered to have a disability if he or she has a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

III. A person will also be considered to have a disability if he or she has acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

For more information regarding the definition of a person with a disability see the HUD Final Rule by clicking here.

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:

Third Party Verification Attached:

☐ Written verification of the disability from a licensed professional;
☐ Written verification from the Social Security Administration or Veterans Administration;
☐ The receipt of a disability check; or
☐ Intake staff-recorded observation of disability, no later than 45 days from the application for assistance, accompanied by supporting evidence listed above. (See appendix for Verification of Disability Form)

NOTE:

As of September 30, 2020 HUD is now entirely waiving the requirement at 24 CFR 578.103(a)(4)(i)(B) that Community Planning Development ESG, CoC and HOPWA programs obtain additional evidence no later than 45 days from the application for assistance to verify intake staff-recorded observations of disability until the end of the pandemic. A written certification by the individual seeking assistance that they have a qualifying disability will be acceptable documentation approved by HUD under 24 CFR 578.103(a)(4)(i)(B)(5) until public health officials determine no additional special measures are necessary to prevent the spread of COVID19.

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	Staff Signature	Date

_____
Agency Name

Chronic Homelessness Determination

Mark 1 of the 3 boxes indicating the applicant's chronic homelessness status below & complete corresponding table

☐ **Chronic Homelessness Verified**

To the best of my knowledge, the Chronic Homelessness Verification Packet is complete and the applicant meets the definition of experiencing chronic homelessness (**Only sign if time homeless and disability have been verified to indicate household is chronically homeless and any necessary forms have been attached**).

_____	_____/_____/_____
Signature of Verifying Worker	Date

☐ **Chronic Homelessness Verification Pending**

If the applicant is marked Verification Pending, the Chronic Homelessness Determination forms should be revisited and updated when the applicant is determined to have moved from **Pending** to **Verified** / **Ineligible.**

Upon review of this packet, this applicant appears to meet the definition of experiencing chronic homelessness but lacks documentation to verify this. Intake staff will pursue further documentation to confirm the applicant's chronic homelessness status and complete the Chronic Homelessness Verification Packet.

_____	_____/_____/_____
Signature of Verifying Worker	Date

The housing provider should immediately move forward with housing the applicant. All third party homeless documentation must be collected within 180 days of the applicant's move-in date. If third party documentation cannot be obtained, a written record of intake worker's due diligence to obtain the documentation of the living situation should be included. All disability documentation should be collected within 45 days of the move-in date.

Move-in date: _____/_____/_____

180 Day Deadline: _____/_____/_____	45 Day Deadline: _____/_____/_____

☐ **Applicant Determined Ineligible**

Upon review, the applicant does not meet the definition of experiencing chronic homelessness:

- ❑ The applicant has not experienced 12 continuous months of homelessness nor 4 distinct occasions of homelessness in the past 3 years that total 12 months.
  - o To the best of my knowledge, the applicant has experienced _____ occasions of homelessness in the past 3 years totaling _____ months. (Please see the Time Accumulation Worksheet)
- ❑ The applicant has not reported nor has staff observed a qualifying disabling condition.

For all referrals determined ineligible, sections 1-4 of this Packet should be uploaded into HMIS

_____	_____/_____/_____
Signature of Verifying Worker	Date

APPENDIX

*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.**

_____(Provider of Record) is seeking verification for the following occasions of homelessness experienced by _____ (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.	_____/_____	5.	_____/_____	9.	_____/_____
2.	_____/_____	6.	_____/_____	10.	_____/_____
3.	_____/_____	7.	_____/_____	11.	_____/_____
4.	_____/_____	8.	_____/_____	12.	_____/_____

Please check the most applicable affiliation of the third party:

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

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

I certify that I encountered _____ (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: _____

Agency: _____Title: _____

Signature of Verifier: _____ Address: _____

Phone Number: _____Date: _____

Authorization for Release of Information

Third Party Homelessness Verification

To: _____ Date: _____

_____

_____

Dear _____,

_____ (Applicant's Name) is applying for a supportive housing program as defined by the U.S. Department of Housing and Urban Development (HUD). The attached Third Party Verification form is part of the eligibility process. We are requesting your assistance in completing and returning this form as quickly as possible to:

_____

Referring / Verifying Agency Address

_____

Contact Person (First,Last) Email Phone

Please contact us with any questions or concerns.

Sincerely,

_____

Signature of Agency Representative

Client Consent for Release

❑ I hereby authorize the release of the information requested in the attached Third Party Homelessness Verification form for the purpose of verifying my eligibility for supportive housing and related services.

_____

Signature of Client Date

OR

❑ I certify that the applicant provided oral consent for the release of the information requested in the attached Third Party Homelessness Verification form for the purpose of verifying their eligibility for supportive housing and related services.

_____

Signature of Agency Representative Date

**This release of information will expire one year from the date of the applicant's written or oral consent indicated above.

VERIFICATION OF DISABILITY
SECTION A

TO BE COMPLETED BY THE HOUSING PROVIDER

_____(Applicant's Name) is applying for a permanent supportive housing program, as defined by the U.S. Department of Housing and Urban Development (HUD).

This form is part of the eligibility process; please contact us with any questions or concerns. We are requesting your assistance in completing and returning this form as quickly as possible to:

Agency Name: _____

Agency Address: _____

Contact Person (First and Last): _____

Phone Number: _____

Email Address: _____

VERIFICATION OF DISABILITY
SECTION B

ONLY A LICENSED PROFESSIONAL WITH CREDENTIALS TO DIAGNOSE AN INDIVIDUAL WITH THE SPECIFIED DISABILITY MAY COMPLETE THIS SECTION.

Eligible Disability Types, please select all of the following that apply:

- ❑ a disability as defined in Section 223(d) of the Social Security Act as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which… has lasted or can be expected to last for a continuous period of no less than 12-months..."

- ❑ a physical, mental, or emotional impairment which is (a) expected to be of long-term, continued, and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions;

- ❑ a developmental disability as defined in Section 102(8a) of the Developmental Disabilities Assistance and Bill of Rights Act. In general, this "… means a severe, chronic disability of an individual that—is attributable to a mental or physical impairment or combination of mental and physical impairments"

- ❑ the disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiological agency for acquired immunodeficiency syndrome

Please check appropriate credentials

❑ Psychiatrist	❑ Physician	❑ Physician's Assistant	❑ Nurse Practitioner	❑ CNP
❑ LCSW	❑ LCPC	❑ Psychologist	❑ CADC	❑ Other: _____

Printed Name: _____

Signature: _____

License Number: _____

Agency / Office Name: _____

Phone Number: _____ Date: _____

Authorization for Release of Information

Verification of Disability

To: _____ Date: _____

_____

_____

Dear _____,

_____ (Applicant's Name) is applying for a supportive housing program as defined by the U.S. Department of Housing and Urban Development (HUD). The attached Verification of Disability form is part of the eligibility process. We are requesting your assistance in completing and returning this form as quickly as possible to:

_____

Referring / Verifying Agency Address

_____

Contact Person (First,Last) Email Phone

Please contact us with any questions or concerns.

Sincerely,

_____

Signature of Agency Representative

Client Consent for Release

- ❑ I hereby authorize the release of the information requested in the attached Verification of Disability form for the purpose of verifying my eligibility for supportive housing and related services.

_____

Signature of Client Date

OR

- ❑ I certify that the applicant provided oral consent for the release of the information requested in the attached Verification of Disability form for the purpose of verifying their eligibility for supportive housing and related services.

_____

Signature of Agency Representative Date

**This release of information will expire one year from the date of the applicant's written or oral consent indicated above.

DUE DILIGENCE TO COLLECT DOCUMENTATION WORKSHEET

Contact Log

Third Party / Agency Name attempted to contact	Type of Contact			Phone Number/ Email or Mailing address used	Date of Contact	Results
	Phone	Email	Letter			
	Phone					
	Phone					
	Phone					
	Phone					
	Phone					
	Phone					
	Phone					

Description of outcome including obstacles encountered. If there were no third parties to contact, please explain:

_____ Signature of Verifying Worker	_____ Date

Chronic Homelessness Self Certification*	
For the purpose of establishing Chronic Homelessness Status, an applicant may provide a Self-Statement to certify more than 3 months of homeless time. Use this form to note the dates associated with each and keep in the clients file.	
Client Name (First and Last)	
Client Date of Birth	
Client Contact information	

Homeless Situation:

I _____ (Applicant Name) certify that I was

- experiencing homelessness (sleeping in a place not meant for human habitation such as living on the streets, in a car, at a park, or on public transportation);
- staying in a homeless emergency shelter;
- staying at a safe haven; OR
- staying in an institutional setting for less than 90 days during the following period(s) of time:

TIME ACCUMULATION WORKSHEET				
Period of Time		Actual Time Period being documented		Location
Occasion # or Break	# of Months Verified	Start Date	End Date	Homeless Situation / Provider / Break / Institution
# of occasions _____	Total Months _____	Start date of 3 year period for Chronic Homeless time calculation (3 years prior to date of assessment or housing interview): _____/_____/_____		

*Include due diligence to acquire 3rd party verification

Client Signature _____ Date _____