DedicatedPLUS Verification Packet

PART A: DedicatedPlus Cover Checklist

Date Associated with this Verification Packet

HMIS/Clarity ID

☐

Name of Program Applicant

Date of Birth

Agency Contact (Name of Person who can answer questions about this packet)

Agency Name

Phone Number of Agency Contact

Email Address for Agency Contact

DedicatedPLUS Homelessness Category (Pick One: Check the box for the DedicatedPLUS category that the client is attempting to qualify under)

☐ Category 1: Chronically Homeless *[Attach: Homelessness History Form and supporting documentation]*

☐ Category 2: In Transitional Housing (TH) that is being eliminated & CH at TH entry *[Attach: TH Program Enrollment Record, Documentation of Chronic Homelessness a t TH Entry, and Letter certifying program closure]*

☐ Category 3: Currently homeless, was admitted and enrolled in PSH within last year, was unable to maintain housing, and was CH at time of entrance into PSH *[Attach: PSH Program Exit Record dated within the last year, and Documentation of Chronic Homelessness at PSH Entry]*

☐ Category 4: In Joint TH-RRH Project & CH at TH entrance *[Attach : Joint TH-RRH Program Enrollment Record, and Documentation of Chronic Homelessness at Joint TH-RRH Entry]*

☐ Category 5: Is homeless, in safe haven, or in emergency shelter for at least 12 months in the last three years but has not done so on four separate occasions *[Attach: Homelessness History Form and supporting documentation]*

☐ Category 6: Receiving assistance through a VA funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system. *[Attach: VA Homelessness Verification Form]*

Verification of Disability (Pick One: Check the box to indicate the type of disability verification that is attached to this packet)

Third Party documentation is required at the time of application. Any of the sources below can be used to fulfill the Third Party documentation requirement. For Categories 2, 3, 4, or 6, this section may be satisfied by attaching the verification of disability that was used to qualify for the original project enrollment.

☐ Verification of Disability Status By a Licensed Professional *[Attach: Verification of Disability Form or a comparable written verification letter]*

☐ Written verification from the Social Security Administration *[Attach: Document from Social Security Administration with individual's name and verification of disability status, such as receipt of disability benefits]*

Verification of Current Homelessness (Pick One: Check the box for the type of current homelessness verification attached.)

☐ HMIS Record of active enrollment in a homeless program *[Attach: Homeless Status Timeline; or HMIS Client Summary; or Enrollment Record]*

☐ Homelessness Verification Form *[Attach: Homelessness Verification Form - completed by 3rd party]*

PART B: DedicatedPlus Homelessness History Form

HMIS/Clarity ID

Name of Program Applicant

Agency Contact

Agency Name

Contact Phone

Contact Email

Instructions:

Section 1. Fill in the name of each month and year in which the client is known to have experienced homelessness, starting with the current month and listing the remaining months in reverse order. Once 12 months of homelessness have been documented for the client, no further months of documentation are required. It is ok to pre-fill all months in reverse chronological order.

Section 2. Review the HMIS Timeline and talk with the client to determine if they experienced homelessness in any month within the past 3 years. (Only 12 months need to be documented.) In the row for each known month, insert an "X" in the "Known Period of Homelessness" column and add an "X" in the appropriate (green) column to designate the place in which the person experienced homelessness.

Section 3. Begin collecting documentation for these periods. As documentation is compiled, indicate an "X" in the relevant documentation column. Documentation is only needed for 12 months. Documentation from HMIS or a third party is needed for at least 4 months. If third party documentation cannot be readily collected, the client can self-certify homelessness for up to 8 of the 12 months. If self-certification of homelessness is used, attempts to collect third party documentation must be recorded on a due diligence form.

1. Months within the last 3 Years		**2.** Place Client Experienced Homelessness						**3.** Documentation of Homelessness				**4.** Page #
Month	**Year**	**Known Period of Homelessness** (Insert "X" If month of homeless)	Place not meant for human habitation	Emergency Shelter	Safe Haven	Hotel/Motel Paid by an Agency	Institution for less than 90 days, and Homeless at Entry	**HMIS Record** (Timeline; Client Summary; or Enrollment printout) or other Enrollment printout	**Homelessness Verification Form** - completed by **3rd party**	**Institutional Paperwork** (Record or Letter specifying Homeless at Entry with Stay < 90 days)	**Homelessness Verification Form** - **self-certified** by Client and **Due Diligence Form**	Assemble homelessness history documentation in order of months listed below. Number all pages and list the respective page # here.
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# MONTHS KNOWN HOMELESS												

Homelessness Verification Form

Name of Program Applicant

Person Completing Form

Agency Name (if applicable)

Contact Phone

Contact Email

Name of Person Providing Oral Statement to Individual Completing this Form (if applicable):

Note: If different sources are needed to verify distinct months, each source should complete their own form.

Type of Verification:

- ☐ Agency Verification of Program Stay
- ☐ Outreach Contact
- ☐ Community Member/Business Owner/Family Observation/Other: _____
- ☐ Professional Encounter
- ☐ Professional Observation
- ☐ Self-Certification (Must be accompanied by Agency Due Diligence Form)

Description of Encounter or Observation in Which Homelessness Was Verified:

- ☐ As a representative of an emergency shelter program, I can confirm that the household was a program participant in the period(s) listed below.
- ☐ As a representative of a safe haven program, I can confirm that the household was a program participant in the period(s) listed below.
- ☐ As a representative of a non-profit organization, I can confirm that my agency paid for at least 51% of the cost for a hotel/motel stay in the period(s) listed below.
- ☐ In my professional capacity, I met with the household in the period(s) listed below. In each of these encounters, the household reported that they were residing in the location listed, and in my professional judgement I found this to be truthful.
- ☐ I observed the person/household sleeping in the evening/early morning hours or observed signs of encampment that made me believe they were living in this location in the period(s) listed below.
- ☐ I experienced homelessness in the period(s) listed below, in the locations listed below.

Most Recent Date Person was Known to be in this location (MM/DD/YYYY)	Type of Location Where Household was Residing (Enter number from list below)

If form is being used to verify prior homelessness, complete table below. 'Most Recent Date' is not needed, if only verifying prior homelessness.

Month (at least one day in the month)	Year	Location Number	Type of Location Where Household was Residing (Use numbers from the list to note the location in which the household was residing)
			1. Unsheltered location--Other than Encampment 2. Unsheltered location--Encampment 3. Housing/Building w/ No running water, electricity 4. Vehicle--Safe Parking Location 5. Vehicle--Other location 6. Emergency Shelter 7. Safe Haven 8. Hotel/Motel (paid for by organization) 9. RV/Camper w/ no running water, electricity 10. Jail 11. Hospital 12. Substance Use Treatment Facility/Rehab 13. Transitional Housing Program 14. House/Apartment--Renter 15. House/Apartment--Owner 16. Living with friend or family member * In some circumstances, some of these locations may not count toward periods of homelessness, but time should be documented so it can be part of a client's history of homelessness and housing.

I certify that, to the best of my knowledge and belief, all the information presented above is true, accurate, and complete.

Signature

Date

Printed Name

Contact Phone or Email

Agency Due Diligence to Acquire 3rd Party Homelessness Verification

HMIS ID

Name of Program Applicant

Instructions: Every provider is required to do their due diligence in obtaining 3rd party verification of an applicant's homelessness history to satisfy HUD's legal requirement for verification of a person's eligibility. One form should be used for each third party source. At least two attempts to reach that source are required before relying on client self-certification.

This document is intended to document and certify the provider's due diligence efforts. All self-certification of homelessness must be accompanied by this form. If the applicant is verifying homelessness using a Third Party, and/or Observation of Homelessness, this form is not required. Each month of Self-Certification of Homelessness requires one Agency Due Diligence to Acquire 3rd Party Homelessness Verification form.

Person Completing Form

Agency Name (if applicable)

Contact Phone

Contact Email

Name of Person Providing Oral Statement to Individual Completing this Form (if applicable)

Month/Year of homelessness being verified

By completing this form, the provider certifies they have taken the following steps to obtain third-party verification from the agency/person listed below, and have the supporting in the file to support these efforts.

Date of Effort	**Description** (Include location, type of interaction, name of person contacted, contact phone or email, how the person was contacted and relationship of the person to the program applicant)	**Outcome of Contact** (e.g. no response, declined to provide third party verification)*

* If the person discloses they do not know the program applicant, another contact should be identified for verification.

Staff Name

Agency Name

Staff Title

Staff Email

Staff Phone

Staff Signature

Date

VERIFICATION OF DISABILITY FORM
Continuum of Care Program

Date: _____

Dear Physician/ Qualified Health Personnel:

_____ has claimed eligibility for a federally funded housing program which requires a household
(Applicant Name)
member to have a qualifying disability. The claim must be certified by a professional licensed by the state to diagnose and treat the disability.

For the purpose of this program, an individual or qualifying household member must meet the definition of 'homeless individual with a disability' which can be found in Section 401 (9) of the McKinney-Vento Act, as amended by the HEARTH Act which is an individual who is homeless and has a disability that is expected to be long-continuing or of indefinite duration; substantially impedes the individual's ability to live independently and could be improved by the providing of more suitable housing conditions. The disability could be any physical, mental, or emotional impairment, including impairment caused by alcohol and/or drug abuse, post-traumatic stress disorder, or brain injury; a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency of acquired immunodeficiency syndrome.

Requested by: _____
(Name of Housing/ Service Provider)

SECTION TO BE COMPLETED BY APPLICANT:

Applicant's Release Authorization:

I, _____ **hereby authorize release of the information below:** _____ on _____.
(Applicant Name) **(Signature of Applicant)** **(Effective Date)**

MEDICAL CERTIFICATION
(SECTION TO BE COMPLETED BY LICENSED PROFESSIONAL)

As a professional licensed by the state to diagnose and treat this disability, it is my determination that the above applicant,

_____, **does have a disability as defined above as of** _____.
(Applicant Name) **(Date)**

Disability is: (Please check the box that applies)

- ☐ Physical Illness or Impairment
- ☐ Serious Mental Illness
- ☐ Substance Use Disorder
- ☐ AIDS or HIV Related Diseases
- ☐ Cognitive Impairments resulting from Brain Injury
- ☐ Post-Traumatic Stress Disorder
- ☐ Developmental Disability
- ☐ Other: _____

Additional information concerning this disability:

This disability is expected to be of long-continuing or of indefinite duration; substantially impairs their ability to live independently and is of such nature that daily functioning and the disability could improve under more suitable housing conditions. ☐ **YES** ☐ **NO**

Printed Name: _____ **License Number:** _____

Professional Title: _____ **Phone Number:** _____

Signature: _____ **Date:** _____

Name of Medical Group: _____

Agency Address: _____

Attach Organization Stamp/Card:

DEFINITION OF DISABILITY
COC PROGRAM

To be eligible for assistance under the CoC Program, an individual or family must meet the definition of homeless as set forth in section 578.3 of the CoC Program interim rule as well as any additional eligibility criteria set forth in the CoC Program NOFA under which the project was funded, which we have provided at the end of this response.

Where disability is an eligibility requirement for the project, the recipient must also document the program applicant's disability. As found in the HEARTH: Defining "Homeless" Final Rule, the following documentation of disability is accepted:

1. Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently; OR
2. Written verification from the Social Security Administration; OR
3. The receipt of a disability check; OR
4. Intake staff recorded during initial assessment, observation of behavior that indicates a disability- must submit no later than 45 days of application for assistance, confirmation and evidence as listed in 1, 2, and 3 of the observed disability; OR
5. Other documentation approved by HUD.

If the disability is not in the form of written verification from the Social Security Administration or in the form of a disability check, then the disability must be verified by a written diagnosis from a professional who is licensed by the state to diagnose and treat that condition. The recipient will need to determine whether the professional who plans to provide the written diagnosis meets HUD's requirement for their state.