DedicatedPLUS Verification Packet

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]*

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												

Los Angeles Continuum of Care
Homelessness Verification

Please complete all sections of this form thoroughly to ensure validity and completeness. This form can be used across ALL homeless programs within the Los Angeles Continuum of Care. For the CoC Program eligibility, Sections 1, 2, and 3A must be completed. *The verification does not expire.*

Name of Program Applicant

HMIS/VSP #

Name of Person Completing Form

Agency Name (if applicable)

Contact Email

Contact Phone

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

1. Description of Encounter or Observation

Choose the relevant option that best describes the encounter of observation used to verify the period(s) homelessness. For multiple verification instances involving different locations or sources, complete separate forms for each instance. Please select only one option per form

☐ 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 or government agency, 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, the household reported that they were residing in the location listed, and in my professional judgment 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.

☐ Self Certification: I experienced homelessness in the period(s) and locations listed below.
Please include an accompanying Agency Due Diligence Form 1446 per month of self-certification.

2. Episodes of Homelessness

List all months including the current month of homelessness that pertains to the description above. Each month must have a corresponding location number.

Month/Year (at least one day in the month)	**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 * In some circumstances, some of these locations may not count towards periods of homelessness, but time should be documented so it can be part of a client's history of homelessness and housing. 10. Undisclosed 11. Jail 12. Hospital 13. Substance Use Treatment Facility/Rehab 14. Transitional Housing Program 15. House/Apartment - Renter 16. House/Apartment - Owner 17. Living with friend or family member

3A. Current Homelessness

Indicate the most recent date when the individual was known to be in this location and specify the location type. If this form is for verifying ongoing homelessness for a housing application, the date provided must be within 7 day of application submission. Please ensure the month listed below is also indicated in Section 2.

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)

3B. Cause of Current Homelessness

Please check the appropriate box if the above indicated episode was caused due to a situation described below.

☐ Self Certification: I am experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other dangerous, traumatic, or life-threatening conditions related to the violence against me or a family member in my or my family's current housing situation, including where the health and safety of children are jeopardized; I have no other safe residence; and I lack the resources or support networks to obtain other safe permanent housing.

☐ In my professional capacity, I can confirm that the participant: is experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized; has no other residence; and lacks the resources or support networks to obtain other safe permanent housing.

☐ None of the above apply.

4. Certification

If program applicant is self certifying under Section 1, they must certify by signing below. In cases of all other encounters or descriptions, the individual verifying must sign below.

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

Printed Name

Contact Phone Number or Email

Signature

Date

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

Los Angeles Continuum of Care
Verification of Disability

RELEASE OF INFORMATION AUTHORIZATION

The individual below signed a release of information giving you permission to supply our agency with information to verify their reported disability. The Individual has either claimed eligibility for a federally funded housing program which requires a household member to have a qualifying disability or the individual is claiming a disability for other purposes. Please complete the section that applies to the individual.

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

on _____.
(Date)

SECTION TO BE COMPLETED BY PERSON WHO HAS OBSERVED THE DISABILITY OR LICENSED MEDICAL PROFESSIONAL

1. **The section below qualifies the applicant for the following programs: Housing Choice Voucher (HCV), Project Base Voucher (PBV), Veterans Affairs Supportive Housing (VASH), and Stability Voucher (SV).**

   Does the individual meet any of the below criteria for the US Department of Housing and Urban Development (HUD) definition of a Person with Disabilities as described below?

   A. A disabled person is one with an inability to engage in any substantial gainful activity because of any physical or mental impairment that is expected to result in death or has lasted or can be expected to last continuously for at least 12 months; or for a blind person at least 55 years old, inability, because of blindness to engage in any substantial gainful activities comparable to those in which the person was previously engaged with some regularity and over a substantial period; or

   B. A developmentally disabled person is one with a severe chronic disability that:

   1. Is attributable to a mental and/or physical impairment;
   2. Has manifested before age 22:
   3. Is likely to continue indefinitely;
   4. Results in substantial functional limitations in three or more of the following areas: capacity for independent self-living, self-caring, receptive, and expressive language; learning, mobility, self-direction, and economic self-sufficiency AND
   5. Requires special interdisciplinary or generic care treatment, or other services which are of extended or lifelong duration and are individually planned or coordinate; or

   C. A disabled person is also one who has a physical, emotional, or mental impairment that:

   1. Is expected to be of long-continued or indefinite duration;
   2. Substantially impedes the person's ability to live independently;
   3. Is such that the person's ability independently could be improved by more suitable housing conditions.

   This disability meets one or more of the criteria for disability mentioned above: **YES** ☐ **NO**

I certify that the person identified above should be considered disabled per the description in section 1. By signing below, I attest to the best of my professional knowledge and belief that all the information is true and correct.

Printed Name: _____ **Agency Name:** _____

Professional Title: _____ **Email:** _____

Agency Address: _____ **Phone Number:** _____

Signature: _____ **Date:** _____

SECTION TO ONLY BE COMPLETED BY A PROFESSIONAL LICENSED BY THE STATE TO BOTH DIAGNOSE AND TREAT THE DISABILITY BELOW

2. This section must be completed for the Continuum of Care (CoC) program.

Does the individual meet the definition of "homeless individual with a disability as defined in Section 401 of the McKinney Vento Act, as amended by the HEARTH ACT?

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.

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: _____

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** ☐

I certify that the person identified above should be considered disabled per the description in section 2. By signing below, I attest to the best of my professional knowledge and belief that all the information is true and correct.

Printed Name: _____ **Agency Name:** _____

Professional Title: _____ **License Number:** _____

Email: _____ **Phone Number:** _____

Agency Address: _____

Signature: _____ **Date:** _____

Attached Organization Stamp/Business Card: