**Triage (with VI) for Placement | Referral | Waitlisting revised** 01/2017

## VULNERABILITY INDEX SCORE (VI Score)

**Place Total in box below at conclusion of interview**

- *Add up the "1s" from all later* pages, and enter at right.
- If the VI = 10 or greater, client is recommended for a PSH or Housing First Assessment.
- If the VI = 6-9, client is recommended for a Rapid Re-housing Assessment.
- If the VI = 0-4, client is not recommended for a Housing and Support Assessment.

**Referral process for "THE CALL"**

Enclosed you will find a triage form and a SPDAT for "THE CALL" (Coordinated Access to Local Links). This process is an initial point of intake for the assessment to assist Homeless individuals or families within the three CoC's (Continuums of Care) in Bristol County- New Bedford CoC, (Homeless Service Providers Network-HSPN), Fall River's CoC (Homeless Service Providers Coalition), and the Greater Bristol County/Attleboro/Taunton coalition to End Homelessness' CoC (GBCATCH). These referrals will be reviewed and entered into the Centralized Waiting List ***only if submitted complete.***

Once received, the referrals are then placed on a centralized waiting list. As vacancies are submitted, the consumer with the highest needs, meet the HUD definition of literally homeless and meets the eligibility requirements for the vacant program will then be referred to the vacancy. Each consumer must originate from the CoC that the vacancy is located in. The program that the referral is sent to is responsible to contact the consumer for a full intake and will request all required documentation.

Please complete all forms completely. All forms must be emailed or faxed to:

Email: Thecall@cssdioc.org

or

Fax #: ATTN: Emergency Solutions Dept.

The Call

508-675-2224

Referring Agency: _____

Agency Address (incl. city/state/zip): _____

Name of Staff who completed this form: _____

Phone of Staff: _____

Email of Staff: _____

Date of Referral mm/dd/yyyy: _____/ _____/ _____

**Triage (with VI) for Placement | Referral | Waitlisting revised** 01/2017

**DO ANY OF THESE SITUATIONS APPLY TO YOU OR SOMEONE IN YOUR HOUSEHOLD?** (choose one only, the most important)

| | | | |
|---|---|---|---|
| ○ Elderly, or Disabled | 1 | ○ Need to leave High-Crime Neighborhood | 12 |
| ○ Displacement for Witness Protection/Hate Crime | 2 | ○ Aging out of Child/Teen Services | 13 |
| ○ Section 236 or Displaced by Gov't Action | 3 | ○ Release from institution into Homelessness | 14 |
| ○ Displacement due to Domestic Violence | 4 | ○ Registered Sex Offender | 16 |
| ○ Displacement due to Health Code Violations | 5 | ○ Local Resident | 17 |
| ○ Displacement due to Urban Renewal | 6 | ○ Local Employee | 18 |
| ○ Displacement due to Natural Disaster / Fire / Water | 7 | ○ Community-Based Housing Certification | 19 |
| ○ Rent-Burdened despite Full-Time Employment | 8 | ○ Homeless due to Health Care/Medical Costs | 10 |
| ○ Rent-Burdened despite Part-Time Employment | 15 | ○ Veteran | 20 |
| ○ Displacement by Landlord or Market Forces | 9 | ○ Seeking reunification after treatment | 21 |
| ○ Internal Transfer (already live here) | 11 | ○ Unaccompanied Youth - Throwaway \| Runaway | 22 |

**WHAT HOUSING WAITLISTS WOULD YOU BE ELIGIBLE FOR?** (choose as many as seem appropriate)

| INDIVIDUALS | FAMILIES | UNACCOMPANIED YOUTH |
|---|---|---|
| ○ **TH**<br>○ **PH**<br><br>**HISTORY OF:**<br>○ **Domestic Violence**<br>○ **Substance Abuse Wet Shelter**<br>○ **Substance Abuse Long Term**<br><br>**SUBPOPULATION:**<br>○ **Veterans**<br><br>○ **Special Needs**<br>○ MH ○ HIV ○ DD ○ Other | ○ **TH** ○*2BR* ○*3BR* ○ *4BR* ○5BR ○ 6BR ○7+<br>○ **PSH** ○*2BR* ○*3BR* ○ *4BR* ○5BR ○ 6BR ○7+<br><br>○ **Veterans**<br>○*2BR* ○*3BR* ○ *4BR* ○5BR ○ 6BR ○7+<br><br>○ **Special Needs:**<br>○ MH ○ HIV ○ DD ○ Other | ○ **Pregnant / Parenting**<br>○ **Runaway / Castaway**<br><br>○ **Special Needs:**<br>○ MH ○ HIV<br>○ DD ○ Other |

Describe current living situation:

_____

_____

_____

_____

Date entered current living situation: _____

Applicant's place of origin ○ **FALL RIVER** ○ **NEW BEDFORD** ○ **GBCATCH**

**(Bristol Co. other than Fall River or New Bedford city limits)**

## WAITLIST PLACEMENT – ALL FIELDS ARE REQUIRED (Vulnerability Index to be completed by CSS staff)

**Head of Household's FIRST Name** in the boxes below, write your first name as it appears on your birth certificate

O

**Head of Household's MIDDLE Name** write your full middle name, not just the initial

O

**Head of Household's LAST Name** (ex: Baez-Gonzalez)

O

O Yes O No **Have you ever served in the military?** **Have you or anyone in your HH experienced DV?** O Yes O No

| **Head of Household's SOCIAL SECURITY NUMBER** | | **GENDER** | **Head of Household's DATE OF BIRTH** | | |
|---|---|---|---|---|---|
| | | | **Month** | **Day** | **Year** |
| O ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | O | | O | | |

| **ETHNICITY** Also provide your race at right! | **RACE:** Asian , Black, White, Native American, Pacific Islander, Multi-racial Do **NOT** write Spanish, Hispanic, Latino here – and do **NOT** write your country! |
|---|---|
| O O Hispanic O non-Hispanic | O |

O **YOUR MOTHER'S MAIDEN NAME**

| **YOUR HOME TELEPHONE** | **SECOND TELEPHONE** (if you have one) |
|---|---|
| O ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ | ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ |

**YOUR EMAIL ADDRESS**

O

**WHERE CAN WE REACH YOU A YEAR FROM NOW?** O same address as shown on the opposite side of this page

**Answer this:** Address is O a P.O. Box O a street address - include any apartment # O a "care of" address

**If "Care of" include the care of person's name in the address line below: ex: "c/o Smith, 19 Flower St #4"**

O

**City, State, and Zip Code:**

O

**SECOND CONTACT or MAILING ADDRESS** O same address as above

**Answer this:** Address is O a P.O. Box O a street address - include any apartment # O a "care of" address

**If "Care of" include the care of person's name in the address line below: ex: "c/o Smith, 19 Flower St #4"**

O

**City, State, and Zip Code:**

O

| **TOTAL HOUSEHOLD SIZE** include yourself | | | | | | **# of Bedrooms** | | **How much money does your family receive in a year?** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | | **# Adults** | | **# Children** | | **Total #** | O | | bedrooms | O | $ | | | | , | | | | **.0** | **0** |

**INCOME SOURCES** fill in the circles next to any income source that your household currently receives O = ●

O

O Job O Pension O Unemployment O SSI O SSDI O SS Retirement O Veteran's Payments O Other

O GA/TANF/TAFDC/Welfare O Disability O Worker's Comp O Child Support/Alimony O Food Stamps

**MOBILE RENTAL ASSISTANCE** Do you currently have rental assistance that you can use to pay rent in our building?

O O I will not bring rental assistance O Section 8 voucher O MRVP O AHVP O VASH or similar O Temp. assistance _____

**ACCOMMODATIONS – DO YOU NEED**

O O Wheelchair Access O No-Steps Unit O First-Floor Unit O Reasonable Accommodation *based on disability or language barrier*

## VULNERABILITY INDEX (PLEASE ANSWER FOR ANYONE IN THE HOUSEHOLD)

| | | |
|---|---|---|
| 1. If Head of Household is ≥60 yrs. or older ○ CR to provide DOB | **2. If yes, enter "1" →** | |
| 2a. Has gone Homeless continuously for at least 12 months? or ○ Yes ○ No ○ CDNK ○ CR<br>2b. Has been homeless at least 4 times in the past three years where the combined occasions total 12 months (occasions must be separated by a break of at least 7 nights)?<br>○ Yes ○ No ○ CDNK ○ CR<br>2c. Has been residing in an institutional care facility for less than 90 days and met all of the criteria in (1) before entering facility ○ Yes ○ No ○ CDNK ○ CR<br>2d. Adult head of household meets criteria in (1) or (2) regardless of family composition fluctuation<br>○ Yes ○ No ○ CDNK ○ CR | **2. If yes to either, enter "1" →** | |
| ○ 3. In the past six months, how many times have you been to the Emergency Room? ○ CR<br>○ 4. In the past six months, how many times have you had an interaction with the police? ○ CR<br>○ 5. In the past six months, how many times have you been taken to the hospital in an ambulance? ○ CR<br>○ 6. In the past six months, how many times have you used a crisis service, including distress centers or suicide prevention hotlines? ○ CR<br>○ 7. In the past six months, how many times have you been hospitalized as an in-patient, including mental health hospitalizations? ○ CR | **If you total the answers 3-7 and it's ≥ "4 times", enter a "1" →** | |
| ○ 8. Have you been attacked or beaten up since becoming homeless? ○ CR<br>○ 9. Have you tried to harm yourself, or threatened to harm yourself, or anyone else, in the last year? ○ CR | **If yes to 8/9, enter a "1" →** | |
| ○ 10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines? ○ CR | **If yes to 10, enter a "1" →** | |
| ○ 11. Does anybody force you or trick you to do things that you do not want to do? ○ CR<br>○ 12. Do you ever do things that may be considered to be risky, like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, or anything like that? ○ CR<br>○ 13. Types of places you may have slept: which one do you sleep at most often?<br>○ Shelter ○ Street ○ Vehicle ○ Bus or Subway ○ Beach, River, Park ○ Other | **If yes to 11/12, or 13 is something <u>other than</u> "Shelter", enter a "1" →** | |
| ○ 17. Do you have planned activities each day other than just surviving? ○ CR | **If no, enter "1" →** | |
| ○ 18. Do you have any friends, family or acquaintances out of convenience or necessity, but you Don't like their company and you wouldn't hang with them unless you had to? ○ CR<br>○ 19. Do any of your friends ever take your money, borrow cigarettes, use your drugs/alcohol, or get you to do things you don't really want to do? ○ CR | **If yes to <u>either or both</u>, enter "1" →** | |
| ○ 20. Where do you usually go for health care? ○ CR | **If "nowhere", enter "1" →** | |
| ○ 21. Do you have Kidney disease / End Stage Renal disease, or Undergo Dialysis? ○ CR | **If yes, enter "1" →** | |
| ○ 22. Do you have History of Frostbite, Hypothermia, or Immersion Foot? ○ CR | **If yes, enter "1" →** | |
| ○ 23. Do you have liver disease, Cirrhosis, or End-Stage Liver Disease? ○ CR | **If yes, enter "1" →** | |
| ○ 24-32. Look at the **Chronic Health Conditions** box on the next page. Enter at "1" on that page if you have any of these conditions. | | |

| | | |
|---|---|---|
| ○ 33. Interviewer: do you detect signs or symptoms of a serious health condition even though client denies any of these? | | |
| ○ **Substance Use**: Alcohol only<br>○ **Substance use:** Drugs only<br>○ **Substance Use:** Both Alcohol and Drug<br>○ 34. Have you ever had problems with drug or alcohol use or been told that you had a problem<br>○ 35. Have you consumed alcohol / drugs every day or almost every day in the past month?<br>○ 36. Have you used injection drugs or shots in the past six months?<br>○ 37. Have you been treated for drug/alcohol problems but then returned to drinking or drugs?<br>○ 38. Have you used non-beverage alcohol like cough syrup, mouthwash, rubbing alcohol, cooking wine, or anything like that in the past six months?<br>○ 39. Have you ever blacked out because of your alcohol / drug use?<br>○ 40. Interviewer: do you observe signs or symptoms of alcohol / drug use even if client denies it? | **If yes to one or more, enter "1" →** | |
| ○ **Physical Disability (missing a limb, blind, deaf, in a wheelchair, etc.** ○ CR | **If yes, enter "1" →** | |
| ○ **HIV/AIDS** ○ CR | **If yes, enter "1" →** | |
| ○ **Mental Health Issues** ○ CR<br>○ 41. Have you ever been taken to a hospital against your will for a mental health reason?<br>○ 42. Gone to an emergency room because of nerves or feeling shaky or scared?<br>○ 43. Spoken with a mental health professional in the last six months? | **If yes to one or more, enter "1" →** | |
| ○ **Developmental Disability**<br>○ 44. Had a serious brain injury or head trauma?<br>○ 45. Ever been told you have a learning disability or developmental disability?<br>○ 46. Have trouble concentrating, or remembering things?<br>○ 47. Interviewer: do you detect signs or symptoms of mental illness or brain functioning? | **If yes to one or more, enter "1" →** | |
| ○ **Chronic Health Conditions:** *If not already answered above*<br>○ Heat stroke/Heat Exhaustion<br>○ Heart diseases, Arrhythmia, or Irregular Heartbeat<br>○ Asthma ○ Cancer<br>○ Diabetes ○ Emphysema<br>○ Hepatitis C ○ High Blood Pressure<br>○ Tuberculosis ○ Alzheimer's<br>○ Other: _____ | **If yes to one or more, enter "1" →** | |
| ○ 48. Have you had any medicines prescribed for you by a doctor that you do not take, or that you sold, misplaced, or had stolen, or where the prescriptions were never filled in the first place? ○ CR | **If yes, enter "1" →** | |
| **!!!!!! If the SA score is "1' AND the Mental Health/Developmental Disability is a "1" AND there is another health condition as well, ENTER a "1" in the BOX AT RIGHT (**Tri-morbidity or multiple serious health conditions**)** → | | |

| **IS THIS PERSON PREGNANT?** | **VICTIM OF DOMESTIC VIOLENCE?** | |
|---|---|---|
| ○ No or N/A ○ Yes If Pregnant, Due Date: _____/_____/_____ | *Use same answers as for Adult HoH* | |
| ○ 49. Have you ever experienced any emotional, physical, psychological, sexual abuse, or trauma in your life which you did not get help for, and/or which you feel has caused your homelessness? | **If yes, enter "1" →** | |
| **TOTAL VULNERABILITY SCORE** (add up the 1s and enter in box at right; **also enter this score at top of page 1, then continue below**.) | | |

# AUTHORIZATION FOR RELEASE OF INFORMATION

## HOW YOUR INFORMATION IS PROTECTED

Any information collected about you in electronic format is not accessible to anyone but your authorized advocate(s), THE CALL [Coordinated Access to Local Links], and eventually to the eligible receiving agency for housing placement.

- We do collect/store anonymous aggregate information for policy purposes but identifying information about you is never released.
- We don't store SSNs and names online; we comply with the tightest possible laws governing your personal information.
- We are "tighter than most banks".

### YOUR ADVOCATE/S NEED YOUR PERMISSION TO SEND THE COMPLETED REFERRAL/APPLICATIONS

I, _____, understand it is my sole responsibility to update my advocate of any change in my information, specifically telephone number and address, as soon as change occurs. I understand that my advocate intends to use the HousingWorks/SimTech system to input and apply for housing. My housing information will be stored electronically and used to search for housing options. I further authorize my advocate to release my demographics and Vulnerability Index Score to the Coordinated Access Local Links otherwise known as "THE CALL". A second possibility is that my advocate can update waitlists I am on with any crucial changes in my application profile. Finally, I understand that if I authorize any other advocates in writing to work for me, then all my advocates will be able to see my housing application information, and have permission to talk with each other. I understand, however, that I can ask one advocate to permanently bar the other housing advocates from my records, if I wish; this lets me keep control over who advocates for me. I can also ask my advocate to show me which advocates have updated my information and when.

My advocate should explain to me what kinds of agencies they generally contact in order to perform housing advocacy:

**Restrictions on the use of Information.** (*Please check one*):

☐ This release lets my advocate request, or provides information from/to all relevant agencies for purposes of my housing search.

☐ This release specifies the *only* agencies [below], that my advocate can contact.

_____ _____

_____ _____

**My signature below acknowledges my understanding, authorization and consent for the following:**

1. This *Authorization for Release of Information* form is valid until it is revoked in writing by the applicant;
2. This authorization is subject to my revocation at any time, except for information already released;
3. This authorization covers the release of that information specified in the previous section and the information to be compiled during the course of client's involvement with the agency or program;
4. I understand that I have a right to receive a copy of this authorization form as well as the *Revocation of Authorization* form.
5. I understand that by signing this release I authorize this agency's auditors and HousingWorks/Simtech support staff to view information contained in my file (for audit purposes only);
6. A copy of this form is as valid as the original;
7. My advocate cannot withdraw any of my applications without documented attempts to contact me. It is my responsibility to stay in touch with the agency unless I revoke their authorization by completing a *Revocation of Authorization* form.

_____ Date: ____/____/____

Client/Parent/Guardian Signature

**How client was informed of the above information** (*Please check one*):

☐ Client read and signed this form
☐ Verbal explanation of this form was provided point by point by advocate
☐ An interpreter was provided

_____ _____ Date: ____/____/____

Printed Name of the Advocate I am authorizing — Signature of the Advocate I am authorizing

THE CALL 1-800-HOMELESS
A program of Catholic Social Services
1600 Bay Street P.O. Box M·So Station
Fall River, MA 02724
Ph: 508.674·4681 ■ Fx; 508~675~2224

Catholic Social Services
Diocese of Fall River

# REVOCATION OF AUTHORIZATION

## HOW YOU CAN STOP AN ADVOCATE FROM WORKING ON YOUR BEHALF

**WRITTEN REVOCATION**: I hereby revoke all authorization for the releases specified on the Authorization for Release of Information form that I previously signed.

_____ Date: ____/____/_____
Signature of Client/Parent/Guardian

**ORAL REVOCATION**: Client/Parent/Guardian revoked all authorizations for the above specified client.

_____ Date: ____/____/_____
Signature of Advocate

**WHAT AUTHORIZATION(S) IS REVOKED?** ☐ Ability to sign applications ☐ Permission to advocate for me in any way.

THE CALL 1-800-HOMELESS
A program of Catholic Social Services
1600 Bay Street P.O. Box M·So Station
Fall River, MA 02724
Ph: 508.674·4681 ■ Fx; 508~675~2224
Catholic Social Services
Diocese of Fall River

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**WHAT AUTHORIZATION(S) IS REVOKED?** ☐ Ability to sign applications ☐ Permission to advocate for me in any way.

THE CALL 1-800-HOMELESS
A program of Catholic Social Services
1600 Bay Street P.O. Box M·So Station
Fall River, MA 02724
Ph: 508.674·4681 ■ Fx; 508~675~2224
Catholic Social Services
Diocese of Fall River

**VERIFICATION OF DISABILITY**

U.S. Department of Housing
and Urban Development
Office of Housing Federal Housing Commissioner

OMB Approval No. 2502-0204

# THE CALL

COORDINATED ACCESS TO LOCAL LINKS
(A PROGRAM OF CATHOLIC SOCIAL SERVICES)
SERVING 3 CONTINUUMS OF CARE WITHIN BRISTOL COUNTY MA

## PERMANENT SUPPORTIVE HOUSING PROGRAM-VERIFICATION OF DISABILITY

DATE: _____

TREATING SOURCE: _____ FROM: _____

_____ _____

_____ _____

SUBJECT: VERIFICATION OF DISABILITY

NAME: _____

ADDRESS: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.
We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown below.
==========
**RELEASE:** I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months.

_____ _____
Signature Date

**Note to Applicant/Tenant:** You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

This form is valid for one year from the date of signature. You have the right to revoke this authorization at any time by notifying your case manager in writing.

INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" in the **applicable box** that accurately describes the person listed above.

1. ___YES ___NO Has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.

2. ___YES ___NO Is a person with a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)), i.e., a person with a severe chronic disability that:

   a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   b. Is manifested before the person attains age 22;
   c. Is likely to continue indefinitely;
   d. Results in substantial functional limitation in three or more of the following areas of major life activity;

      (1) Self-care,

      (2) Receptive and expressive language,

      (3) Learning,

      (4) Mobility,

      (5) Self-direction,

      (6) Capacity for independent living, and

      (7) Economic self-sufficiency; and

   e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

3. ___YES ___NO Is a person with a chronic mental illness, i.e., he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

4. ___YES ___NO Is a person whose sole impairment is alcoholism or drug addiction.

_____ _____

NAME AND TITLE OF PERSON SUPPLYING THE INFORMATION

FIRM/ORGANIZATION
Address: _____
_____
_____

_____ _____

SIGNATURE DATE

==========

**Public reporting burden** for this collection is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This information is required to obtain benefits and is voluntary. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. Owners/management agents must obtain third party verification that a disabled individual meets the definition for persons with disabilities for the program governing the housing where the individual is applying to live. The definitions for persons with disabilities for programs covered under the United States Housing Act of 1937 are in 24 CFR 403 and for the Section 202 and Section 811 Supportive Housing for the Elderly and Persons with Disabilities in 24 CFR 891.305 and 891.505. No assurance of confidentiality is provided. The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937, as amended (42 U.S.C. 1437 et. seq.); the Housing and Urban-Rural Recovery Act of 1983 (P.L.98-181); the Housing and Community Development Technical Amendments of 1984 (P.L. 98-479); and by the Housing and Community Development Act of 1987 (42 U.S.C. 3543).
==========

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government; HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security numbers are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a) (6), (7) and (8).


**THE CALL**

COORDINATED ACCESS TO LOCAL LINKS

(A PROGRAM OF CATHOLIC SOCIAL SERVICES)

SERVING 3 CONTINUUMS OF CARE WITHIN BRISTOL COUNTY MA

# VERIFICATION OF HOMELESSNESS

Date:_____

Client/Participant/Guest Name: _____

Control Number for THE CALL (if known) _____

The above referenced person or family has been under the care of this facility from

_____ to _____

*Additional detail about the client's episodes of homelessness may be written below.*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Before coming to this facility, the homeless person resided at:

_____

This facility is classified as one of the following types of facilities/ programs:

□ Emergency Shelter
□ Transitional Housing
□ Permanent Housing
□ Medical Institution
□ Mental Health Facility
□ Correctional Facility
□ Substance Abuse Facility
□ Other: _____

Signature: _____ Date: _____
(Signature of Facility Staff)

Title: _____ Phone: _____

This person has completed a comprehensive housing search and no subsequent residence has been identified and the client lacks resources and support networks needed to obtain housing. The resident is being referred to your agency's housing program.

The person was homeless prior to entering this facility as evidenced below:

_____ Residing in a place not meant for human habitation

_____ Residing in an emergency shelter, transitional housing, or exiting an institution where they were placed for less than 90 days

---

Signature of referral Source

---

Title of Referral Source

---

Agency

---

Contact Phone Number Date

# CHRONICALLY HOMELESS CERTIFICATION

**THIS CHRONICALLY HOMELESS CERTIFICATION MUST BE COMPLETED FOR EACH HOUSEHOLD.**

Agency /Program Name: _____

Individual/Household Name: _____ Date Form Completed: _____

**This form is to certify the above individual or household is currently chronically homeless based on the category checked and required documentation.**

---

**1**

**HOW DO THEY MEET THE CHRONICALLY HOMELESS DEFINITION?**

The individual/household meets the definition of chronic homelessness* because he/she is a single individual or a head of household with a disability living in a place not meant for human habitation, safe haven or in an emergency shelter who has experienced homelessness… (*check one appropriate box)*

☐ …continuously for at least 12 months, during which time they may have lived in a shelter, safe haven or a place not meant for human habitation.

☐ …over a period of 4 or more separate episodes totaling 12 months in the last 3 years that were separated by breaks of *at least* 7 nights between each episode. *(Stays in institutions for less than 90 days do not constitute a break.)*

☐ …living in a shelter, safe haven or a place not meant for human habitation *before* exiting an institutional care facility like a jail, prison, substance abuse or mental health facility, hospital or similar facility after spending less than 90 days there.

☐ …is a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in option 1 or 2 of this section, including a family whose composition has fluctuated while the head of household has been homeless.

**Refers to HUD definition which became effective January 15, 2016. See page 4 for additional resources and HUD links.*

---

**2**

**WHAT EVIDENCE HAS BEEN PROVIDED TO DOCUMENT CHRONIC HOMELESS STATUS?**

It has been verified that the individuals/household whose primary nighttime residence is a public or private place not meant for human habitation, or who are living in a publicly/privately operated shelter designated to provide temporary living arrangements (like congregate shelters and motels paid for by charitable organizations or public dollars), have been documented as meeting the definition of chronic homelessness through the following standard documentation: *(check each appropriate box)*

☐ Third party documentation (*proceed to question 2a*).

☐ Intake worker observation (*proceed to question 2b*).

☐ Certification from the person seeking assistance (*proceed to question 2c*).

**2a**

**Third party documentation** has been provided and is present in the case file in the following way: *(check all appropriate boxes)*

☐ HMIS records that retain an auditable history of all entries (example: "who, what, when") and prevent overrides or changes of the dates of entries.

☐ A written referral by another housing or service provider.

**2b**

**Intake Worker Observation** has been provided and is present in the case file in the following way: *(check all appropriate boxes)*

- ☐ Written observation(s) by an outreach worker of the conditions where the individual was living.
- ☐ Written referral by another housing or service provider.
- ☐ Evidence of due diligence to secure third party documentation and the individual's self-certification of the living situation is documented in the case file.

**2c**

**Certification from the person seeking assistance** is available to all clients for up to 3 months of their homelessness but in limited circumstances, up to 12 months can be obtained through self certification where there is evidence in the case file that third party documentation and initial worker observations are unavailable. In the case of self-certification, both of the following items must be documented:

- ☐ Written self-certification.
- ☐ The intake worker's documentation of the individual/household's living situation and evidence of due diligence in attempting to obtain third party documentation and intake worker observation.

Has evidence that the individual/household has experienced homelessness for 12 months included a combination of these three forms (i.e. 2a, 2b or 2c) of standard documentation? *(Check one box):* ☐ YES ☐ NO

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**3**

**WHAT ABOUT INSTITUTIONAL CARE?**

If an individual resided in an institutional care facility for 90 days or less and was chronically homeless before entering the facility, the following evidence of homelessness—*in addition to* the standard documentation already noted in this section—is also required. *(Check appropriate box to reflect which documentation has been provided in the case file).*

- ☐ Discharge paperwork or a written/oral referral from a social worker, case manager or other appropriate official of the institutional care facility stating the start and end dates of the individual's stay, or
- ☐ Where discharge paperwork cannot be obtained, a written record of the intake worker's due diligence in attempting to obtain it and a certification by the individual that they exited the facility where the individual or head of household resided for less than 90 days.

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**4**

**HOW HAS DISABILITY BEEN DOCUMENTED?**

Those qualifying under the chronic homeless definition must meet the standards demonstrating homelessness, but they must also demonstrate evidence of a disability. *(Check all appropriate boxes to reflect which documentation has been provided in the case file).*

- ☐ Written verification of the disability from a professional licensed by the state to diagnose and treat the disability AND his/her certification that the disability is expected to be long-continuing or of indefinite duration and that it substantially impedes the individual/head of household's ability to live independently.
- ☐ Written verification from the Social Security Administration.
- ☐ Receipt of a disability check (e.g. SSDI, Veterans Disability Compensation).
- ☐ Intake staff-recorded observation of disability that—no later than 45 days from the application for assistance—is confirmed and accompanied by at least one other piece of evidence.
- ☐ Other documentation as may be approved by HUD and the City of New Bedford.

## 5 ARE THE 12 MONTHS OF HOMELESSNESS CONTINUOUS OR CUMULATIVE?

Those identified as being chronically homeless must be literally homeless and living either in a place not meant for human habitation, in a safe haven or in an emergency shelter for 12 months or longer. *(Check one box to reflect whether the individual/household being documented was continuously or cumulatively homeless and complete the documentation section for the selected option).*

☐ **Continuous**

The chronically homeless persons must be homeless and living in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for 12 months or greater.

*Check any boxes that may apply:*

☐ If records show that there are not 12 months of continuous homelessness in HMIS with no break, but the client reports that they have been homeless for the last 12 months with no breaks, other third-party sources providing adequate documentation are now in the case file.

☐ In rare and extreme cases, if at least 9 months of continuous homelessness cannot be obtained by third party documentation, up to the full 12 months can be documented through self-certification, only. If this has been done, evidence of documented attempts to obtain third-party documentation and why the third-party documentation was not obtained must be included within the case file along with a written certification from the individual or head of household of the living situation for the undocumented period.

☐ **Cumulative**

For chronically homeless persons experiencing 4 or more occasions of homelessness over a period of 3 years, the cumulative total of the occasions must be 12 months or greater.

*Check one box, only:*

☐ A review of HMIS data demonstrated that there were 12 months of cumulative homelessness over the last 3 years and is documented in the case file.

☐ Although HMIS data did not demonstrate 12 months of cumulative homelessness over the last 3 years, other third party sources were identified and documentation of the homeless episodes totaling 12 months has been documented in the case file.

☐ Although there were fewer than 3 breaks found in HMIS, the client was able to identify additional breaks between separate occasions of homelessness that brought the total to 4 or more occasions of homelessness over the past 3 years. This self-certifying information is documented in the case file.

☐ In rare and extreme cases, if at least 9 months of cumulative homelessness cannot be obtained by third party documentation, up to the full 12 months can be documented through self-certification, only. If this has been done, evidence of documented attempts to obtain third-party documentation and why the third-party documentation was not obtained must be included within the case file along with a written certification from the individual or head of household of the living situation for the undocumented period.

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**STAFF CERTIFICATION**

All of the information identified on this form has been placed in the client's case file.

Intake Staff Signature: _____

Date Form Completed: _____

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## PART 1: INSTRUCTIONS

☐ Complete all fields in Part 2 ☐ Complete all relevant fields in Part 3

☐ Attach all supporting documents to this form ☐ Maintain this form & supporting docs in participant's file

*See Part 4 for Detailed Instructions & Part 5 for a Quick Guide to Eligibility*

## PART 2: GENERAL INFORMATION

| Participant Name: | Participant Date of Birth: | Participant HMIS #: |
|---|---|---|
| | | |
| **Person Completing Form:** | **Agency Completing:** | **Date Form Completed:** |
| | | |

**Email & Phone Number for Person Completing Form:**

Email: Phone #:

| CoC Program for which Homelessness is Being Certified: | CoC Program Type: ***(Check One)*** | | | CoC Project Entry Date: |
|---|---|---|---|---|
| | ☐ PSH | ☐ TH | ☐ RRH | |

## PART 3: CURRENT HOMELESS STATUS & HOMELESS HISTORY

**Location Prior to CoC Program Entry:** *Indicate place where client was staying immediately prior to program entry* ***(Check One):***

***Required Documentation Must Be Attached*** *(See Part 4).*

☐ Unsheltered ☐ Emergency Shelter

☐ Rapid Re-housing ☐ Transitional Housing (not qualified as chronic)

☐ Hotel/Motel Paid by Govt or Charity ☐ Institution < 90 days & literally homeless prior

**Is client fleeing or attempting to flee domestic violence** *(**Check One**)*? ☐ **YES** ☐ **NO**

***Required Documentation Must Be Attached* (See requirements in Part 4).**

**Homeless Status *(Check One)***

☐ Literally Homeless (includes <90 days institution) ☐ Imminent Risk of Homelessness ☐ Fleeing Domestic Violence

**Chronic/Disability Status**

Is this participant chronically homeless? (SEE HOMELESS HISTORY) ☐ YES ☐ NO ***If yes, to any, Disability Verification***

Is this participant being qualified for permanent supportive housing? ☐ YES ☐ NO ***must be completed.***

Is this participant being qualified for transitional housing for disabled? ☐ YES ☐ NO

**Homeless History - EXAMPLE**

*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 and must be separated by at least a 7 night break when the individual did not meet the 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. Each month can be counted only once. To qualify a participant as chronically homeless, you must document at least 12 consecutive months or at least 4 separate occasions within the last three years of living unsheltered, in ES, or in another qualified location provided that the total time homeless during those occasions equals at least twelve months.*

***Required Documentation Must Be Attached*** *- For more details, including institutional stays & doc requirements, see Part 4.*

| | Program Name or Location | Program/Location Type | Start Date | End Date | Length of Stay | Occasion # |
|---|---|---|---|---|---|---|
| ***SAMPLE*** | *Riverside Park* | *Unsheltered* | *Aug 2014* | *12/23/14* | *Aug-Dec: 5 months* | *Occasion #1* |
| | Veteran's | *Housed* | *12/24/14* | *1/2/15* | *10 days = break* | *Not Homeless* |
| | *Harbor House* | *Emergency Shelter* | *1/3/15* | *1/10/15* | *January: 1 month* | *Occasion #2* |
| | *Riverside Park* | *Unsheltered* | *1/11/15* | *2/2/15* | *February: 1 month* | |
| | *Southcoast* | *Institutional Stay < 90 days* | *2/3/15* | *4/15/15* | *March-April : 2 months* | |
| | *John's House* | *Residential Rehab > 90 days* | *4/16/15* | *8/30/15* | *4+months=break* | *Not Homeless* |
| | *Sister Rose* | *Emergency Shelter* | *8/31/15* | *11/5/15* | *Aug-Nov: 4 months* | *Occasion #3* |
| | *Friends/Family* | *Housed* | *11/6/15* | *End of Jan* | *2+months=break* | *Not Homeless* |
| | *Bus Station* | *Unsheltered* | *End of Jan* | *2/5/16* | *Jan-Feb: 2 months* | *Occasion #4* |
| TOTAL # Occasions (red lengths do not count towards total): | | | | | 15 months | 4 Occasions |

***SAMPLE PARTICIPANT QUALIFIES AS CHRONICALLY HOMELESS.***

**Homeless History – ENTER PARTICIPANT INFO BELOW**

*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 and must be separated by at least a 7 night break when the individual did not meet the 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. Each month can be counted only once. To qualify a participant as chronically homeless, you must document at least 12 consecutive months or at least 4 separate occasions within the last three years of living unsheltered, in ES, or in another qualified location provided that the total time homeless during those occasions equals at least 12 months.*

***Required Documentation Must Be Attached*** **-** *For more details, including institutional stays & doc requirements, see Part 4.*

| Program Name or Location | Program/Location Type | Start Date | End Date | Length of Stay | Occasion # |
|---|---|---|---|---|---|
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| *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.* ***ENTER CHRONIC STATUS ON PAGE ONE.*** | | | | **TOTAL # OCCASIONS:** | |
| | | | | **TOTAL # MONTHS:** | |

| Signature of Person Completing Form: | Certification: | Date |
|---|---|---|
| | ☐ **CHECK BOX TO CERTIFY THAT ALL REQUIRED DOCUMENTS ARE ATTACHED.** | |