VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

Ventura County Continuum of Care
Homeless Documentation Checklist

Instructions: This recommended checklist should be used as a guide to confirm homeless status eligibility for housing programs.
Please use the attached forms, to satisfy HUD requirements for Permanent Housing eligibility.

DISABILITY DOCUMENTATION
Check and include documentation of one of the following. The diagnosis must be verified and documented by a licensed professional who can diagnose and is currently treating the condition.

- ☐ A diagnosable substance abuse disorder causing an impairment due to alcohol or drug abuse
- ☐ A developmental disability
- ☐ A serious mental illness
- ☐ A posttraumatic stress disorder, or brain injury
- ☐ A chronic physical illness or disability, including the co-occurrence of two or more of these conditions.
- ☐ Other

Supportive Documentation Required for Disability (*attach one*)

- ☐ A letter from a medical professional attesting to the presence of the condition and is signed by a licensed professional that is able to diagnose and treat the noted condition the state of California.
- ☐ (SSI, SSDI or Veteran's Disability) A written verification from the SSA/VA or a copy of the disability check is attached.

CRITERIA FOR DEFINING HOMELESS

Category 1: Literally HOMELESS STATUS:

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Category 2: Imminent Risk of Homelessness

Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Category 4: Fleeing/ Attempting to Flee DV

Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing

Reviewed On (Date): _____ Signature(SME)_____

Supportive Documentation Required for Homeless Status: Attach one or more of the following. Documentation must include the client is Category 1: Literally Homeless Status, Category 2: Imminent

Risk of Homelessness or Category 4: Fleeing/ Attempting to Flee DV. Examples of documentation to be included are listed below:

Category 1: Literally HOMELESS STATUS

- ☐ Certification letter(s) from an emergency shelter for the homeless OR
- ☐ Certification letter(s) from a homeless service provider or outreach worker OR
- ☐ Certification letter(s) from any other health or human service provider OR
- ☐ Self-Certification from the individual of head of household seeking assistance

- ☐ For individuals exiting an institution- one of the forms of evidence above AND:
  - ☐ Discharge paperwork or written/ oral referral, or
  - ☐ Written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution

Category 2: Imminent Risk of Homelessness

- ☐ A court order resulting from an eviction action notifying the individual or family that they must leave; OR
- ☐ For individual and families leaving a hotel or motel- evidence that they lack the financial resources to stay OR
- ☐ A documented and verified oral statement AND
- ☐ Certification that no subsequent residence has been identified AND
- ☐ Self-certification or other written documentation that the individual lack the financial resources and support necessary to obtain permanent housing

Category 4: Fleeing/ Attempting to Flee DV

For victim service providers:

- ☐ An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker

For non-victim service providers:

- ☐ Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; AND
- ☐ Self-certification or other written documentation that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

Criteria and Recordkeeping Requirements for Definition of Homelessness Resource:

https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf,

Additional Supportive Documentation for Veterans and Income

Supportive Documentation Required Veteran Status *(if applicable):*

☐The DD Form 214, Certificate of Release or Discharge from Active Duty
Additional questions:

1) Yes ☐ or No ☐: Person served in the active military, naval or air service of the U.S. or as a member of the National Guard for a period of not fewer than 90 consecutive days or was discharged from service due to a service-related disability. This includes veterans with other-than-honorable discharges.
2) Yes ☐ or No ☐: Is the Veteran connected to VA Healthcare? If no, refer to Oxnard VA Clinic 805-204-9135 to establish healthcare services.
2) Yes ☐ or No ☐: The DD 214 Form is attached. If no, refer to Veteran Services Office 805-477-5155 to make an appointment.

Supportive Documentation Required for Income Verification *(if applicable):*
Third-party income verification will be required from all sources, including but not limited to:

☐ Employment, Self-Employment

☐ Savings and checking

☐ Pension

☐ Disability

☐ Asset verification, property, home, stocks, bonds, annuities, IRA, etc.

☐ Government assistance, A.F.D.C., food stamps, etc

☐ Social Security

☐ Child Support/Alimony

☐ Non-Tuition Financial Aid.

Client Name:	**Date of Birth:**
Number in Household:	**Client Head of Household:** ☐ Yes ☐ No

Part 1: Current Housing Status

Client must currently be in one of these locations to be considered literally homeless, imminent risk or fleeing/ attempting to flee DV.

Client is currently residing:

- ☐ In an Emergency Shelter
- ☐ On the Streets/Place not Meant for Human Habitation (car, encampment, etc)
- ☐ In a Safe Haven
- ☐ In an Institutional Care Facility (Where they have been for fewer than 90 days)
- ☐ Imminent Risk of Homelessness
- ☐ Imminent Risk of Homelessness due to Fleeing/ Attempting to Flee DV

Start Date: _____	**End Date:** _____

Location Name/Address:

Current Housing Status Notes:

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Third Party Verification of Homeless Status

Instructions*: This form can be completed by an outreach work, social service provider, healthcare provider, law enforcement officer, shop keeper, neighbor, friend, community member or qualified person who can verify the client's homeless status. A letter or email from a provider is also acceptable documentation.*

*Please specify where you **physically witnessed/observed** the client living and your relationship to the client:*

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dates: ___Month_/__Day___/__Year__ (example)

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

I certify that _____ has been homeless and staying in places not meant for human habitation or emergency shelters for the periods of time listed above:

Signature: _____ Date: _____

Title: _____ Phone: _____

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Referral from Outside Service Provider Verification of Homeless Status

***Instructions**: This form can be completed by a social service provider, healthcare provider, or qualified person who provided services to the client and the client reported they are homeless. A letter or email from a provider is also acceptable documentation.*

*Please specify where your **client presented for services, where THEY reported to be living** and **your relationship** to the client:*

_____

_____

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_____

Dates: ___Month_/__Day___/__Year__ (example)

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

_____/_____/_____, _____/_____/_____, _____/_____/_____,

I certify that_____has been homeless and staying in places not meant for human habitation or emergency shelters for the periods of time listed above:

Signature: _____ Date: _____

Title: _____ Phone: _____

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Self-Statement Certification

I certify that I was homeless **OR** At-Risk of Homelessness **OR** Fleeing/ Attempting to Flee DV during the time noted below:

Date_____/_____/_____, I lived at _____

Date_____/_____/_____, I lived at _____

Date_____/_____/_____, I lived at _____

What else would you like to share about your history? For example, *"I can't remember the name of the place where I was living during the fall of 2004 but I believe that it was a homeless emergency shelter. I have problems with my memory from that time due to an illness."*

_____

_____

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_____

I certify that the above information is correct.

_____ _____

(Signature of Client) (Date)

I reviewed the above statement with the client.

_____ _____ _____

(Signature of Staff Witness) (Organization) (Date)

Intake Worker: What steps were taken to verify this information? _____

_____

_____

_____

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Permanent Housing
Certification of Disability for Program Eligibility Purposes

(form to be completed by a licensed professional, certified to treat the condition listed below)

RE: _____

(Name of Applicant/Resident)

I authorize the release of information, relative to my physical or mental impairment, to _____to verify whether my disability is covered by the definitions below. This information will be used to verify my eligibility for the housing program.

Client Signature: _____ Date: _____

The individual named above is an individual with **(Check appropriate box(es) if the Professional has diagnosed and is <u>currently treating</u> the specific Disability)**:
Regulations in H.E.A.R.T.H. Act require that the disability must always be specifically identified in order to be able to confirm eligibility.

☐ Mental Disability (Serious mental illness) _____

☐ Chronic Physical Illness or Disability _____

☐ Developmental Disability _____

☐ Substance Use Disorder _____

☐ Post-Traumatic Stress Disorder _____

☐ Cognitive impairments resulting from brain injury _____

In my professional opinion, the applicant meets the definition of a Disabled Person, as defined above.

_____ _____
Signature Date

_____ _____
Printed Name Phone Number

_____ _____
Professional Title Email

_____
Address City State Zip

(Please complete back of form)

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Permanent Supportive Housing
Certification of Disability for Program Eligibility Purposes

The definition of a disabled person includes a person who meets any <u>one</u> of the following criteria:

The term homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has a disability that:

☐ *Is expected to be long-continuing or of indefinite duration;*

I. Substantially impedes the individual's ability to live independently;
II. Could be improved by the provision of more suitable housing conditions; and
III. Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

☐ *Is 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*

☐ *Is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.*

In my professional opinion, the applicant meets the definition of a Disabled Person, as defined above.

_____ _____
Professional Title Signature Date

_____ _____
Printed Name Phone Number

Part 4: Client Certification:

To the best of my knowledge and ability, all the information provided in this document is true and complete. I also understand that any misrepresentation or false information may result in my participation being cancelled or denied, or in termination of assistance. It is my responsibility to notify _____ of any changes in my housing status or address in writing during program participation and I understand that my application may be cancelled if I fail to do so.

Client Name: (Printed)	**Client Signature:**	**Date:**

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: (Printed)	**Staff Signature:**	**Date:**
Staff Role:	**Agency:**	

Notes: