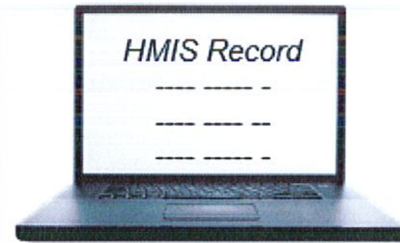
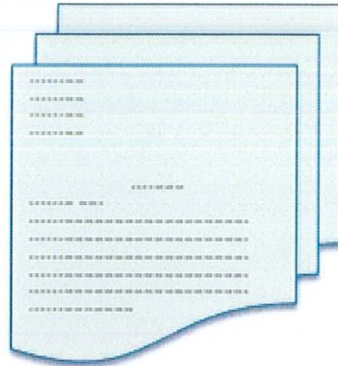
csnance@broward.org

Broward County CPD/HIP Proposed Chronicity Packet

Chronic Homelessness Definition

This tool provides some sample recordkeeping tools for the Chronic Homelessness Definition. To review the exact language, please refer to 24 CFR Parts 91 & 578 and the HUD Exchange.

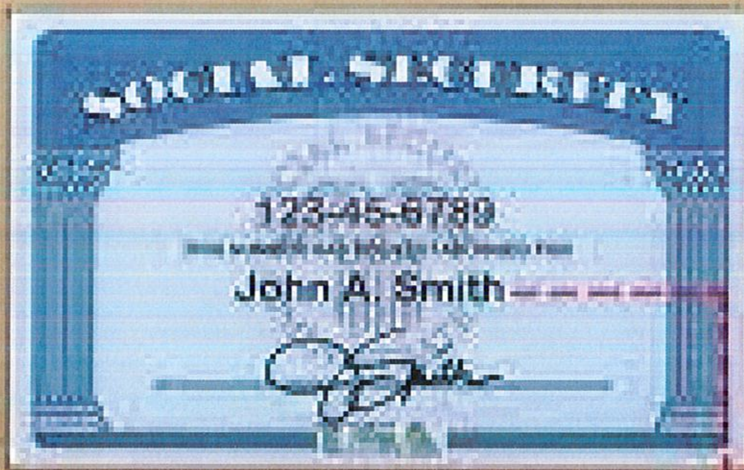
Recordkeeping Documentation Options Explained

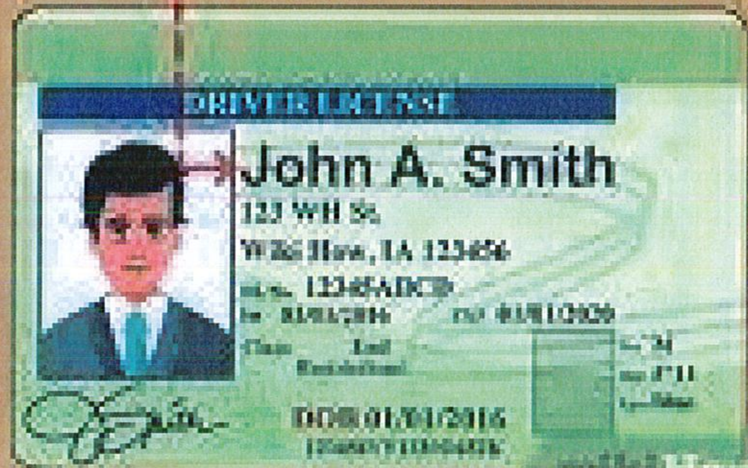
3rd Party Documentation	 Documentation from HMIS/Comparable Database *Records must show entries/exits at Shelters.* *An answer of "Yes" to the question as to whether the individual is chronically homeless (Universal Data Element 3.917) is not sufficient.*	 Written observation by an outreach worker or Written referral by another housing or service provider	Documentation from Institutions like Hospitals, Correctional Facilities, etc. *Must include records about stay the length of stay, signed by Clinician or other appropriate staff.*
Self Certification	Signed certification by the individual seeking assistance describing how they meet the definition, which must be accompanied by the intake worker's documentation of the living situation and the steps taken to obtain evidence to support it. Remember that for each Project: • 100% of households served can use self-certification for 3 months of their 12 months, • 75% of households served need to use 3rd Party documentation for 9 months of their 12 months, and • 25% of households served can use self-certification as documentation for any and all months.		

When do you need third party documentation?

Preferred to record all occasions of homelessness to document Chronic Homelessness.

Not necessary to record breaks in homelessness, these can be based on self reports.


SOCIAL SECURITY
123-45-6789
John A. Smith


DRIVER LICENSE
John A. Smith
wikiHow

STATE OF FLORIDA

BUREAU OF VITAL STATISTICS

CERTIFICATION OF BIRTH

STATE FILE NUMBER: [illegible] DATE FILED: November [illegible], [illegible]

CHILD'S INFORMATION

NAME: JOHN ANDREW SMITH

DATE OF BIRTH: November [illegible] TIME OF BIRTH (24 HOUR): [illegible]

SEX: MALE BIRTH WEIGHT: 7 LBS [illegible] OZ

PLACE OF BIRTH: HOSPITAL
SOUTH MIAMI HOSPITAL

CITY, COUNTY OF BIRTH: SOUTH MIAMI, MIAMI-DADE COUNTY

MOTHER'S INFORMATION

MAIDEN NAME: MARY ADAMS

DATE OF BIRTH: January 15, 1985

BIRTHPLACE: Portugal

FATHER'S INFORMATION

NAME: STEPHEN SMITH

DATE OF BIRTH: March 8, 1982

BIRTHPLACE: New York, USA

DATE ISSUED: November [illegible]

State Registrar

[illegible]

CERTIFICATION OF VITAL RECORD

HOMELESS CERTIFICATION

Applicant Name: ____

☐ Household without dependent children (complete one form for each adult in the household)
☐ Household with dependent children (complete one form for household)
Number of persons in the household: _________

This is to certify that the above named individual or household is currently homeless based on the check mark, other indicated information, and signature indicating their current living situation.

Check only one box and complete only that section

Living Situation: place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

☐ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus station, airport, or camp ground.
Description of current living situation:

____

____

Homeless Street Outreach Program Name: ____

This certifying agency must be recognized by the local Continuum of Care (CoC) as an agency that has a program designed to serve persons living on the street or other places not meant for human habitation. Examples may be street outreach workers, day shelters, soup kitchens, Health Care for the Homeless sites, etc.

Authorized Agency Representative Signature: ______________________________ Date: ______________

Living Situation: Emergency Shelter

☐ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a supervised publicly or privately operated shelter as follows:

Emergency Shelter Program Name: ____

This emergency shelter must appear on the CoC's Housing Inventory Chart submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Emergency Shelter).

Authorized Agency Representative Signature: ______________________________ Date: ______________

Living Situation: Transitional Housing

☐ The person(s) named above is/are currently living in a transitional housing program for persons who are homeless. The persons(s) named above is/are graduating from or timing out of the transitional housing program:

Transitional Housing Program Name: ____

This transitional housing program must appear on the CoC's Housing Inventory Chart submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Transitional Housing program).

Immediately prior to entering transitional housing the person(s) named above was/were residing in:
☐ emergency shelter OR ☐ a place unfit for human habitation

Authorized Agency Representative Signature: ______________________________ Date: ______________

SAMPLE

Chronic Homelessness Documentation Checklist

An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months). Breaks in homelessness, while the individual is residing in an institutional care facility will not count as a break in homelessness. Additionally, an individual who is currently residing in an institutional care facility for less than 90 days and meets the above criteria for chronic homelessness may also be considered chronically homeless. Lastly, a family with an adult/minor head of household who meets the above mentioned criteria may also be considered chronically homeless, despite changes in family composition (unless the chronically homeless head of household leaves the family).

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 in order to be considered chronically homeless.

Client is currently residing:

☐ In Emergency Shelter
☐ On the Streets/Place not Meant for Human Habitation
☐ In the Safe Haven
☐ In an Institutional Care Facility (Where they have been for fewer than 90 days)

Start Date: ______________________________	**End Date:** ______________________________

Location Name/Address:

Current Housing Status Notes:

Part 2: Housing History

	Month # 1	Month # 2	Month # 3	Month # 4	Month # 5	Month # 6	Month # 7	Month # 8	Month # 9	Month # 10	Month # 11	Month # 12
Mo./Yr.	(Current Month)											
Location *Check all that Apply*	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)
Doc. Type *Check One* *(Except Self-Cert. select both)*	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence
Doc. Att.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Break Mo./Yr. & Descr. or N/A	Break 1: Break 2: Break 3: If there are additional breaks please detail and attach.
Notes	
Self-Cert. Check	Does the documentation include more than 3 Months of Self-Certifications? * ☐ Yes ☐ No ** Please be advised that if you answered **YES**, that for at least 75% of the households assisted by a recipient in a project during an operating year, no more than 3 months can be self-certified. **Please check with you project administrator to ensure your project has not exceeded its self-certification cap.***
Key	*Mo. = Month, Yr. = Year, Inst. = Institution, Doc. = Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description*

Part 3: Disability Status

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;*
  - *Substantially impedes the individual's ability to live independently;*
  - *Could be improved by the provision of more suitable housing conditions; and*
  - *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.*

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:

Documentation Attached:

☐ Written verification of the disability from a licensed professional;

☐ Written verification from the Social Security Administration;

☐ The receipt of a disability check; or

☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Disability Notes:

Part 4: Staff and Client Certifications

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:

Agency Name

Address
City, State, ZIP
000-000-000

Name
Address
City, State, ZIP

Enter Date

To Whom It May Concern,

I ______________________, am a ______________________ (job title) with ______________(agency). I certify that to have known ____________________to be homeless. This agency has had contact with the individual on the following months:

(List Month/ Year here)

Thank You,

(Insert Signature)

Social Security TPQY

```
 ***  REC 2015231  113137 H5062481 ANDZ  CIPQYA4   PQA4   (P-AND )  ***

TPQY   DTE:08/19/15  SSN:                       DOC:037 UNIT:MM        PG: 001
STATUS   MBR YES LOU-08/19 SSACCS NO  LOU-@@@@@ SSR YES LOU-
INPUT SOCIAL SECURITY NUMBER                 NAME  C JANIS      USER CODE MM
TPQY CONFIDENTIAL SOCIAL SECURITY DATA - CLAIM NUMBER
***INFORMATION***
NO MATCH AS OF 08/19/15
INPUT SOCIAL SECURITY NUMBER                 NAME               USER CODE MM
TPQY CONFIDENTIAL SUPPLEMENTAL SECURITY INCOME DATA ON
                      MALE BORN:            ELIGIBLE:06/1982
APPLICATION DATE: 06/25/1982 TYPE OF PERSON: DISABLED INDIVIDUAL
CITIZEN/ALIEN CODE: N
MAILING ADDRESS:



NET CURRENT BENEFIT FOR 08/01/2015 - FED AMT:  $0.00 STATE AMT:  $0.00
PAYMENT HISTORY OF NET BENEFITS PAID:
DATE:         FEDERAL AMT:  STATE AMT:  TYPE OF PAYMENT:
 08/01/2014  $    0.00      $    0.00    NONE MADE
PAYMENT STATUS CODE: T31 - TERMINATED BY SYSTEMS ACTION EFFECTIVE 10/1999
 DISABLED
INPUT SOCIAL SECURITY NUMBER                 NAME               USER CODE MM
***INFORMATION***
***D O REVIEW REQUIRED***
ENTITLEMENT DISCREPANCY BETWEEN MBR & SSR:
  SSR SHOWS MBR CURRENT PAY - MBR NIF/NO MATCH
```

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

OMB Approval No. 2502-0204
(Exp. 06/30/2017)

Appendix 6-B: SAMPLE VERIFICATION OF DISABILITY WHEN ELIGIBILITY FOR ADMISSION OR QUALIFICATION FOR CERTAIN INCOME DEDUCTIONS IS BASED ON DISABILITY

FOR USE WITH ALL PROGRAMS **EXCEPT** SECTION 202/8, SECTION 202 PAC, SECTION 202 PRAC, AND SECTION 811 PRAC

DATE:

TO: FROM:

RETURN THIS VERIFICATION TO THE PERSON LISTED ABOVE (or other instructions to the third party to ensure that the verification is returned to the right person. This is important because owners have a responsibility to treat this information confidentially.)

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. Enclosed is a self-addressed, stamped envelope for this purpose. The applicant/tenant has consented to this release of information as shown above.

==

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 disability, as defined in 42 U.S.C. 423, which means;

   a. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; or

b. In the case of an individual who has attained the age of 55 and is blind, inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time.

For the purposes of this definition, the term blindness, as defined in section 416(i)(1) of this title, means central vision acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for the purposes of this paragraph as having a central visual acuity of 20/200 or less.

2. ___YES ___NO Has a physical, mental, or emotional impairment that:

a. Is expected to be of long-continued and indefinite duration;
b. Substantially impedes his or her ability to live independently; and
c. Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.

3. ___YES ___NO Has 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.

4. ___YES ___NO Is the above a person whose disability is based **solely** on any drug or alcohol dependence (the person has no other disability which meets the above definition).

____
NAME AND TITLE OF PERSON SUPPLYING THE INFORMATION

____
FIRM/ORGANIZATION

____
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).

==

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. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

________________________________ ____________________
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.

==

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 number 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).

Client - (32219) ZZ000032219, Test1

(32219) ZZ000032219, Test1
Release of Information: Ends 03/04/2024

Client Information | **Service Transactions**

Needs | Services | Referrals | Shelter Stays | **Entire Service History**

All Service Transactions

Select Dates | **Start Date** | **End Date**

Transaction Type	Date	Provider	Type	Need Status / Outcome	Need Goal
Need	03/19/2021	Housing Options Service Team (HOST) (PROGRAM)	Emergency Shelter	Identified / Service Pending	
Referral	03/19/2021	Family Prioritization List	Emergency Shelter		
Need	03/15/2021	Family Success (AGENCY)	Emergency Shelter	Identified / Service Pending	
Referral	03/15/2021	Family Prioritization List	Emergency Shelter		
Need	03/05/2021	Broward County / Ft. Lauderdale CoC (AGENCY)	Rapid Re-Housing Programs	Closed / Fully Met	
Referral	03/05/2021	RRH - IND (Rapid Re-Housing)	Rapid Re-Housing Programs		
Need	10/15/2020	Broward County / Ft. Lauderdale CoC (AGENCY)	Homeless Permanent Supportive Housing	Closed / Fully Met	
Referral	10/15/2020	ZERO:2016 - IND (Coordinated Assessment)	Homeless Permanent Supportive Housing		
Need	10/15/2020	Broward County / Ft. Lauderdale CoC (AGENCY)	Rapid Re-Housing Programs	Closed / Fully Met	
Referral	10/15/2020	RRH - IND (Rapid Re-Housing)	Rapid Re-Housing Programs		
Need	10/09/2020	Broward County / Ft. Lauderdale CoC (AGENCY)	Homeless Permanent Supportive Housing	Closed / Fully Met	
Referral	10/09/2020	ZERO:2016 - IND (Coordinated Assessment)	Homeless Permanent Supportive Housing		
Need	10/09/2020	Broward County / Ft. Lauderdale CoC (AGENCY)	Rapid Re-Housing Programs	Closed / Fully Met	
Referral	10/09/2020	RRH - IND (Rapid Re-Housing)	Rapid Re-Housing Programs		
Need	09/24/2020	Family Prioritization List	Housing/Shelter	Identified	
Need	09/17/2020	Broward County / Ft. Lauderdale CoC (AGENCY)	Rapid Re-Housing Programs	Identified	
Need	09/17/2020	Broward County / Ft. Lauderdale CoC (AGENCY)	Homeless Permanent Supportive Housing	Identified	

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