**CHARLOTTE-MECKLENBURG CONTINUUM OF CARE**

COMMON APPLICATION FOR PERMANENT SUPPORTIVE HOUSING

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| **WHAT IS PERMANENT SUPPORTIVE HOUSING (PSH)?** |

In Charlotte-Mecklenburg, Permanent Supportive Housing (PSH) is a program that combines a rental subsidy with supportive services. In 2015, the Charlotte-Mecklenburg Continuum of Care (CoC) adopted the notice issued by the U.S. Department of Housing and Urban Development (HUD) to prioritize individuals and households who are chronically homeless for permanent supportive housing bed units.

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| **HOW IS PSH ADMINISTERED IN CHARLOTTE-MECKLENBURG?** |

When individuals and households in Charlotte-Mecklenburg enter the homeless services system through Coordinated Assessment (CA), anyone who is identified as chronically homeless is also screened using VI-SPDAT (Vulnerability Index—Service Prioritization Decision Assistance Tool.) The VI-SPDAT generates a score based on multiple factors and helps to identify those individuals and households most in need of housing. In Charlotte-Mecklenburg, individuals and households that are hardest to serve, have the longest episodes of homelessness, and the highest service needs—thus a priority for a Permanent Supportive Housing intervention.

Specifically, those chronically homeless individuals and families with the longest cumulative length of time homeless and the highest VI-SPDAT scores are prioritized.

When housing becomes available, the individual or household at the top of the prioritization list with a completed Common Application for Permanent Supportive Housing is matched with the provider who has the opening. Unless the applicant indicates a preference for a particular program, the first available housing opening at an agency for which they are eligible will receive this completed application and contact the applicant and referring agency about entering their program

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| **WHAT IS THE PURPOSE OF THIS APPLICATION?** |

The purpose of this application is to provide participating housing programs preliminary information for client intake as well as to collect and report data that is consistent with the the Department of Housing and Urban Development (HUD) recordkeeping requirements and ensure consistency with the Charlotte-Mecklenburg Continuum of Care (CoC) prioritization of chronically homeless individuals and families for local PSH slots.

For questions about this application, please contact Megan Coffey at megan.coffey@mecklenburgcountync.gov

An overview of the Permanent Supportive Housing programs in Charlotte-Mecklenburg is provided in Appendix A.

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| **APPLICATION INSTRUCTIONS** |

In **Section 8**, “Verification of Homeless Status / Chronically Homeless” you must provide documentation of homelessness and/or chronic homelessness and describe the applicant’s current homeless situation and in detail any prior episodes of homelessness for the past three years. Listed below are situations that will quality an applicant as homeless and how to document them:

1. **“Street” homelessness:** a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; includes places like a car, a park, an abandoned building, under a bridge/overpass, a camping ground, sleeping in a tent in the woods, etc.

**How to document it:** The above situation must be personally observed and verified, and described in a letter by a third party. An outreach team worker, law enforcement or other person who has witnessed the situation can serve as the third party verification. Currently, family and friends are not eligible to be third party verification sources. In the letter, include specific locations, dates and in what way the situation constitutes a place not meant for human habitation. The letter must be on agency letterhead (if from an agency) and must be signed and dated by the author. Please also include the nature of the relationship between the third party verification source and the applicant.

1. **Emergency Shelter:** a supervised publicly or privately operated shelter designated to provide temporary living arrangements. This includes emergency shelters, domestic violence shelters, Safe Havens, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state or local government programs for low-income individuals.

Note: “Safe Haven” refers to certain HUD-funded apartment-based programs for chronically homeless disabled individuals; persons living in Safe Havens are considered homeless.

**How to document it:** For shelters and Safe Havens, include in the application a letter from the facility verifying the date(s) or entry and exit and that the applicant currently resides there, if applicable; **or** a printout from the HMIS system showing recorded shelter stays. For transitional housing programs, include a letter from the transitional housing program verifying the date of entry and current residence of the applicant; **and** documentation that the applicant’s housing immediately prior to the transitional program was either emergency shelter or a place not meant for human habitation (same documentation as detailed above). For an emergency stay in a hotel/motel, include a letter from the agency that paid for the stay and a copy of the hotel/motel receipt. For all of the homeless settings described above, the referral source must also complete the acknowledgment of homelessness section and provide their signature and date.

1. **Institutional Stays:** a person is considered homeless if they exited an institution whether they stayed for 90 days or less and lived in an emergency shelter or place not meant for human habitation immediately before entering that institution. An institution includes a medical or psychiatric hospital; an in-patient treatment program; a nursing home, respite bed situation or other typically congregate setting; and jail or other correctional facilities.

**How to document it:** Attach a signed and dated letter from the institution verifying that the applicant has lived there for 90 days or less and is about to exit the institution; **and** documentation that the applicant’s housing immediately prior to the institution was either an emergency shelter or a place not meant for human habitation (same documentation as described in 1 and 2, above).

**Important**: In order to document chronic homelessness, you must provide third party documentation for at least 9 months of the 12 months of total homelessness in both the continuous and multiple occasion criterion. If the applicant qualifies as chronically homeless through 4 separate homeless occasions in the past 3 years, the 4 occasions must add up to equal at least 12 months of homelessness. In addition, each break between homeless occasions must last at least 7 days. It is not necessary to have third party documentation for the break; self-report by the applicant is sufficient.

In **Section 9**, “Verification of Disability,” an approved source for verification must be provided.

* If you choose to provide written verification of the disability from a clinical professional licensed by the state of North Carolina to diagnose and treat the condition, that professional must complete that accompanying section, provide their signature and license number, and include supporting documentation for the disability.
* If you choose to use verification from the Social Security Administration, you must include an official letter from the Social Security Administration that documents the disability status.
* The disability must be one of the following: Substance Use Disorder, Serious Mental Illness, Developmental Disability, Post-Traumatic Stress Disorder (PTSD), cognitive impairments resulting from a brain injury, or chronic physical illness or disability. For more information about these disabilities, see Appendix B.

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| **APPLICATION CHECKLIST** |

**Please make sure that ALL components below are completed prior to submitting the application.**

* **Sections 1-10 must be filled out completely.**
	+ Section 3 is optional, *but the information within it can help to speed up the process for housing if included.*
	+ For Section 5 if there are *no* other adults or minor dependents in the household, please complete Question 40, and then skip to Section 6.
* **The applicant must complete and sign all informed consent sections.**
* **Section 8: Verification of Homeless Status / Chronic Homelessness must be completely filled out with at least ONE option checked and signed by the referring person.**
* **Section 9: Verification of Disability must be completely filled out with ONE option checked.**
* **At least 9 months of the 12 months of required homelessness (continuous or multiple episode criterion) must be documented by a third party and described in detail. *See Application Instructions for more information.***
* **Appendix C: Third Party Verification Form for Homelessness/Chronic Homelessness is completed and attached if this option is selected in Section 8.**
* **Appendix E: Verification of Disability Form for Clinically Licensed Professionals is completed and attached if this option is selected in Section 9.**
* **The applicant has ALL required forms of identification and proof of income, if any, for all members of the household.** These include:
	+ State-issued picture ID for head of household
	+ Proof of Social Security number or legal non-citizen status for head of household
	+ Copy of birth certificate for any minors in the household
	+ Proof of a social security number or legal non-citizen status for any minors in the household

All information obtained is confidential and will be used for application review purposes only. The participating organizations maintain a firm commitment to equal opportunity for all applicants and do not discriminate based on race, sex, age, color, national origin, religion, sexual orientation, HIV status, or disability.

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| **SECTION 1: REFERRAL INFORMATION** |

*The referring person/agency can be different from the clinically licensed professional that completes the disability verification.*

1. Name of Referring Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of Referring Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Referral Source Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Referral Source Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Length of time worked with applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION 2: CONTACT & BASIC INFORMATION** |

*This purpose of this section is to gather basic information about the applicant, including contact information so that the Permanent Supportive Housing provider can locate the applicant when their bed unit becomes available. It also requests their HMIS ID and information, which is important for linking their record.*

1. Applicant Name (First, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Second Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Emergency Contact: (First, Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Emergency Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note:*** *If applicant is staying in an* ***emergency shelter or other transitional housing site****,*

*list facility name and address below.*

1. Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Facility Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Facility City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Facility State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Facility Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Where did you stay prior to entering this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Unique HMIS ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Coordinated Assessment Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. VI-SPDAT Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION 3: *OPTIONAL: BACK-UP CONTACT INFORMATION*** |

*This section is optional: You may provide an alternative contact in the event that the contact information changes for the applicant changes and we cannot locate them to notify them of housing and/or need additional information to complete their application.*

1. Back up Contact Name (First, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Second Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION 4: DEMOGRAPHIC INFORMATION** |

*The purpose of this section is collect information that is consistent with the recordkeeping requirements set by HUD and which are required within HMIS.*

1. Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Primary Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Secondary Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION 5: OTHER HOUSEHOLD MEMBER INFORMATION** |

*This section is optional. Please complete Question 40. If the answer is a “single, unaccompanied individual,” please skip to Section 6 after completing the question. Otherwise, complete this section for all households with more than one person.*

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| 1. Is this applicant a single unaccompanied individual, or the head of a household with additional household members?
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*Reminder: if your answer is Head of Household, please complete the information below for additional members in the household. If the applicant is a single, unaccompanied individual, skip to the next section.*

Please complete the following questions for each additional household member:

|  |  |
| --- | --- |
| Household Member 1 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

|  |  |
| --- | --- |
| Household Member 2 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

|  |  |
| --- | --- |
| Household Member 3 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

|  |  |
| --- | --- |
| Household Member 4 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

|  |  |
| --- | --- |
| Household Member 5 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

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| Household Member 6 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

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| --- | --- |
| Household Member 7 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

|  |  |
| --- | --- |
| Household Member 8 |  |
| Name (First, Last): |  |
| Relationship to Head of Household: |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Gender: |  |
| Race: |  |
| Ethnicity: |  |
| If applicable, disability: |  |
| Does household member receive income? |  |
| If yes, what is the source of income? |  |
| If yes, what is the amount of the income? |  |

1. What is the total number of individuals in the household (including the applicant)? \_\_\_\_\_\_\_\_\_\_\_

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| **SECTION 6: PSYCHOSOCIAL INFORMATION** |

*The purpose of this section is to identify the psychosocial strengths and challenges for the applicant as it relates to their housing and eligibility for a Permanent Supportive Housing program. This information can also be used by Permanent Supportive Housing programs to inform support plans for service after the applicant enters the program.*

Strengths, Goals & Support

1. What are applicant's strengths?

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1. What are applicant's goals?

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1. What does the applicant hope to accomplish once housed that they have not been able to do while in their current homeless situation?

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1. Provide names of persons who can provide support to applicant during stressful times.

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Housing History

1. Does applicant meet required definition for homelessness (either Category 1 or 4)?
* Category 1: Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided (HEARTH “Homeless” Definition Final Rule, 2011).
* Category 4: Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member (HEARTH “Homeless” Definition Final Rule, 2011).
* No, the applicant does not meet the required definition. Please do not continue to complete this application, if the applicant does not meet the Category 1 or 4 definition.

In order to verify the applicant’s homelessness, please complete **Appendix C: Third Party Verification Form for Homelessness/Chronic Homelessness** and attach to the application.

1. Has applicant ever maintained a lease in subsidized housing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What was the reason for leaving this housing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational History

1. What is the highest grade that applicant completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income History

1. Does applicant have income (earned or unearned)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is the source for applicant's income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What is the monthly amount of income received? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does applicant have a pending application to receive income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Does applicant receive EFT (food stamps)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. If answer is yes, please provide amount of monthly food stamps: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Does applicant receive other benefits (Medicaid/VASH, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. If yes, please provide Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. If yes, please list benefits and amounts currently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. If applicable, please list assets currently owned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Veteran History

1. Is applicant a veteran? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*HUD Definition of Veteran: Someone who has served on active duty in the Armed Forces of the United States.*

*If applicant is not a veteran, please skip to next section.*

1. Veteran Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Branch of Military: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Years Served: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does applicant have a DD214? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The DD-214 is a discharge document issued by the United States Department of Defense to military service members upon retirement, separation, or discharge from the military. The DD-214 contains information that is needed for a veteran to apply for benefits from the U.S. Department of Veterans Affairs.*

1. Discharge Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health, Trauma & Substance Use History

*The information below is to be completed by the referral source and can be completed using self-report from the applicant, observations and supporting documentation. In order to verify a disability, a clinically licensed professional must complete the* **Appendix E: Disability Verification Form for Clinically Licensed Professionals** *if there is no documentation from the Social Security Administration in the form of a letter or check (See Application Instructions for more information).*

1. Current Mental Health Diagnosis(es):

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1. Is applicant currently receiving treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Provide name of treatment provider:

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1. Current Medications:

|  |
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1. Does applicant have a history of substance use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Names of substances used:

|  |
| --- |
|  |

1. Has applicant experienced problems related to their substance use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is applicant currently receiving treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Provide name of treatment provider:

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1. Has applicant received treatment for substance use in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If so, provide dates and length of treatment period:

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1. Is applicant a survivor of domestic abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If yes, provide dates of abuse:

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| --- |
|  |

Medical Condition

1. Current medical diagnosis(es):

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| --- |
|  |

1. Is applicant currently receiving treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of current Primary Care Provider:

|  |
| --- |
|  |

1. Phone Number for Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Criminal Justice History

*The information below is to be completed by the referral source and can be completed using self-report from the applicant, observations and supporting documentation. If the applicant has no criminal history, please select No to the first question and skip ahead to the next section.*

1. Has applicant ever been arrested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Provide dates of arrests:

|  |
| --- |
|  |

1. Has applicant ever been charged with a felony? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If the answer is yes, was the felony related to arson or the production of methamphetamines?

|  |
| --- |
|  |

1. If applicable, please provide dates and nature of offense for all felonies:

|  |
| --- |
|  |

1. Has applicant ever been charged for a drug-related offense while living in a subsidized apartment?

|  |
| --- |
|  |

1. Is applicant currently listed on a sex offender registry? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is applicant currently on probation or parole for an offense? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Summary for Referral Source

1. Include 2 to 3 of the applicant's strengths related to their housing:

|  |
| --- |
|  |

1. Include 2 to 3 areas for improvement as they envision living their best lives (examples include acquire new hobbies, family reunification, health/wellness goals, etc.):

|  |
| --- |
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| **SECTION 7: INFORMED CONSENT & SIGNATURES** |

*The purpose of the section below is to inform the applicant of how their information will be used and stored and how it relates to their application for permanent supportive housing. Please review the statements with the applicant prior to their signing. It also provides acknowledgement statements for both the applicant and referral source that the information provided on the application is accurate and the potential consequences for the application if there is false information provided.*

For Applicant:

By signing below, I understand that the information I have provided will be used to verify my eligibility for the permanent supportive housing program. This information will be entered into the Homeless Management Information System (HMIS), which is an information system that stores data on persons experiencing homelessness in the community.

|  |  |
| --- | --- |
|  |  |

Signature of Applicant Date

For Applicant:

By signing below, I acknowledge that I have provided answers to the questions to the best of my knowledge. I understand that if I provide false answers to any of the questions that it could impact my eligibility for permanent supportive housing programs.

|  |  |
| --- | --- |
|  |  |

Signature of Applicant Date

For Referral Source:

By signing below, I acknowledge that I have reviewed the previous sections of the application with the applicant and have completed all required answers to the best of my knowledge.

|  |
| --- |
|  |

Name of Referral Source (First, Last)

|  |  |
| --- | --- |
|  |  |

Signature of Referral Source Date

|  |
| --- |
| **SECTION 8: VERIFICATION OF HOMELESS STATUS / CHRONICALLY HOMELESS STATUS** |

*Please see the Application Instructions for completing this section. If the applicant qualifies as homeless, please complete Section 1: Homeless Status Verification. If the applicant qualifies as chronically homeless, please complete Section 2: Chronically Homeless Status Verification. Please complete* ***only 1*** *of these sections.*

|  |  |  |
| --- | --- | --- |
|  |  |  |

Today’s Date Applicant’s First Name Applicant’s Last Name

**SECTION 1: HOMELESS STATUS VERIFICATION**

*Permanent Supportive Housing programs by definition can serve populations who experience homelessness through HUD’s categories 1 and 4 of homelessness (literal homeless and fleeing domestic violence). In Charlotte-Mecklenburg, 100% of Permanent Supportive Housing beds have been prioritized for the population who meets the definition of chronic homelessness. If you are completing this application with a person who does not meet the definition of chronic homelessness, complete this first section: Homeless Status Verification. However, the person may not be prioritized for a Permanent Supportive Housing bed if there is a waiting list with other persons who meet the chronic homelessness definition.*

Please Choose Only 1:

* Applicant qualifies as homeless under Category 1: Literally Homeless:

*(An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: has a primary nighttime residence that is a public or private place not meant for human habitation; is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by government or charitable organizations; or is exiting an institution where (s)he has been a resident for 90 days or less and who resident in a shelter (but not transitional housing) or place not meant for human habitation immediately prior to entering that institution.)*

* Applicant qualifies as homeless under Category 4: Fleeing / Attempting to Flee Domestic Violence:

*(An individual or family who: is fleeing, or is attempting to flee, domestic violence; has no other residence; AND lacks the resources or support networks to obtain other permanent housing.)*

Please Check Verification Method:

* 1. For **Category 1 (Literally Homeless),** choose **only 1** of the following:
		+ **Third Party**: Written referral by another housing or service provider or observation by Outreach Worker. *(The content on this form can be copied and pasted on the referral agency's letterhead, and must include the applicant's name along with dates and locations for homeless episodes. The letter must also be dated and signed by authorized staff and include the agency's name, address and contact information.)* See Appendix C.
		+ **Intake Worker Observation**
		+ **Self-Certification** by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter. See Appendix D.

***For individuals exiting an institution***, please select one of the methods above and select an additional method below:

* + - Discharge paperwork or written/oral referral
		- Written record of intake worker's due diligence to obtain evidence and certification by individual that they exited an institution
	1. For **Category 4 (Fleeing / Attempting to Flee Domestic Violence),** choose **only 1** of the following:
		+ **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 certification by the individual or head of household that no subsequent residence has been identified; and self-certification, or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

**SECTION 2: CHRONICALLY HOMELESS VERIFICATION**

*In order to meet the criteria for chronic homelessness, the applicant must meet both homelessness and disability criteria. They must meet the criteria for either 1, 2 or 3.*

1. The applicant meets the criteria for chronic homelessness:
	1. **An Individual who:**
		* Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
		* Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years
		* Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.
	2. **An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or some similar facility, for fewer than 90 days and met all of the criteria in # (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility**.
	3. **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 # (1) of this definition and includes a family whose composition has fluctuated while the head of household has been homeless.**

Please check verification method:

* + **Third Party**: Written referral by another housing or service provider or observation by Outreach Worker. See Appendix C for Template.
	+ **Intake Worker Observation**
	+ **Self-Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter.** See Appendix D.

Please indicate which type of homeless criterion the applicant meets (choose only 1):

* + **Continuous 1-year period:** Applicant has been homeless for 12 consecutive months without any breaks and referral source is able to verify that at least 9 of the 12 months can be documented through third party verification.
	+ **Multiple Occasions:** Applicant has been homeless for at least 4 separate occasions in the last 3 years AND the 4 separate occasions total 12 months of homelessness. A single occasion of homelessness must be separated by at least 7 consecutive days of non-homelessness. The referral source is able to verify that at least 9 of the 12 months can be documented through third party verification.

*Note: A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider the individual or family as homeless for the entire month unless there is evidence that the household has had a break in homeless status during that month.*

Please provide details on the period(s) of homelessness:

1. Please indicate the time periods that the applicant was homeless below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Homeless Occasion | Start date of homeless occasion | End date of homeless occasion | Number of days break between homeless occasion | Location of applicant during homeless occasion | Location of applicant prior to homeless occasion |
| 1 |  |  | N/A |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
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| 9 |  |  |  |  |  |
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1. Total months of homelessness across homeless occasions:

|  |
| --- |
|  |

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| --- |
| **SECTION 9: VERIFICATION OF DISABILITY** |

*Please see the Application Instructions for completing this section.*

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| --- | --- | --- |
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Today’s Date Applicant’s First Name Applicant’s Last Name

1. Please select source for verification of disability (you can choose more than 1):
	* **Written verification of the condition from a clinically licensed professional** (see Appendix E) by the state to diagnose and treat the condition.
	* **Written verification from the Social Security Administration**
	* **Copies of a disability check** (e.g. Social Security Disability Insurance Check or Veterans Disability Compensation)
	* **Intake / Referral staff observation**. This option must be confirmed by written verification of the condition from a clinically licensed professional, licensed by the state to diagnose and treat the condition that is confirmed no later than 45 days of the application for assistance and accompanied with one of the types of evidence above.

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| **SECTION 10: VERIFICATION OF IDENTITY AND SOCIAL SECURITY NUMBER** |

*The purpose of this section is to provide information to the Permanent Supportive Housing Provider that is required for their recordkeeping and also to ensure all documentation needed for moving into permanent housing is received.*

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| --- | --- | --- |
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Today’s Date Applicant’s First Name Applicant’s Last Name

1. Please initial that you have attach a legible copy of current Photo ID is attached.
2. Legible Copy of Social Security Card or print out from Social Security Administration stating Social Security Number is Attached.

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| **APPENDIX A: OVERVIEW OF PSH PROGRAMS IN CHARLOTTE-MECKLENBURG** |

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| --- | --- |
|  PROGRAM | DESCRIPTION |
| HousingWorks:Moore Place | Serves unaccompanied chronically homeless adults (no couples or families). There are 85 one-bedroom efficiency apartments located in one building with 24-hour security, an on-site laundry room and a computer lab. Support services are provided on-site by a team that includes social workers, counselors, and a nurse. Social/recreational activities are arranged by the tenant services coordinator. Participation in services is encouraged but not required. Sobriety and /or compliance with a treatment plan is not required, but tenants are expected to maintain the requirements of a standard apartment lease. Income is not required at entry, but all tenants are expected to work towards obtaining a source of income once housed. Individuals with income pay 30% of their income for monthly rent.  |
| HousingWorks: Scattered-Site | Serves unaccompanied chronically homeless adults (no couples or families). Tenants are housed in apartments throughout Charlotte. The ability to house someone can be limited by criminal background. All tenants are assigned a case manager and other case managers provide support as necessary. Tenants may also participate in activities and resources offered at Moore Place. Participation in services is encouraged but not required. Sobriety and /or compliance with a treatment plan is not required, but tenants are expected to maintain the requirements of a standard apartment lease. Income is not required at entry, but all tenants are expected to work towards obtaining a source of income once housed. Individuals with income pay 30% of their income for monthly rent and pay for utilities. |
| HUD-VASH | Scattered-site housing for veterans and veteran families. Veterans must be eligible for medical care through VA (i.e., at least 2 years of service with Honorable, Under Honorable, or General discharge), currently experiencing homelessness (with a priority on chronically homeless, families with minor children, female veterans, and veterans who recently returned from Afghanistan or Iraq), and have case management needs.  No minimum income requirement, maximum income is 30% AMI. |
| Shelter + Care | Scattered site housing for hard to serve homeless and chronically homeless individuals and families. Participant must demonstrate the ability to live independently in the community. Tenants are expected to maintain the requirements of a standard lease. Income cannot exceed very low (50% AMI) income limits. Income is not required however all participants are expected to work towards obtaining some income source through employment, entitlements, etc. Participants with income pay 30% of their income towards rent and utilities. |
| Supportive Housing Communities: McCreesh Place | Serves chronically homeless men. There are 64 single rooms with shared baths and kitchens and 27 efficiency apartments located in one building with 24-hour security, an on-site laundry room and an exercise area, community room, and computer lab. Support services are provided on-site seven days a week. Social and recreational activities are scheduled monthly. McCreesh Place is an alcohol and drug free community and all residents agree to random drug and alcohol screenings. Some criminal background may be a barrier. Residents are expected to pay a $75 minimum rent and the maximum income is 30% AMI. However, exceptions can be made for applicants wishing to enter without income.  Tenants without income are expected to work towards obtaining a source of income once housed. Individuals with income pay 30% of their income for monthly rent. |
| Supportive Housing Communities: Scattered-Site | Serves homeless men and women. Tenants are housed in apartments throughout Charlotte. All tenants are provided with support services on-site. Tenants may also participate in activities and resources offered at McCreesh Place. Sobriety and /or compliance with a treatment plan is not required, but tenants are expected to maintain the requirements of a standard apartment lease. Some criminal background may be a barrier. Income is not required at entry, but all tenants are expected to work towards obtaining a source of income once housed. Individuals with income pay 30% of their income for monthly rent and pay for utilities. |

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| **APPENDIX B: OVERVIEW OF DISABILITIES THAT QUALIFY FOR CHRONIC HOMELESSNESS** |

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| DISABILITY | DESCRIPTION |
| Substance Use Disorder[[1]](#footnote-1) | A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period:* Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.
* Recurrent substance use in situations in which it is physically hazardous.
* Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
* Tolerance, as defined by either of the following:
	+ A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
	+ Markedly diminished effect with continued use of the same amount of the substance.
* Withdrawal, as manifested by either of the following:
	+ The characteristic withdrawal syndrome for the substance.
	+ The same or a closely related substance is taken to relieve or avoid withdrawal symptoms.
* The substance is often taken in larger amounts or over a longer period than was intended.
* There is a persistent desire or unsuccessful efforts to cut down or control substance use.
* A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
* Important social, occupational, or recreational activities are given up or reduced because of substance use.
* The substance use is continued despite knowledge of having a persistent or recurrent or psychological problem that is likely to have been caused or exacerbated by the substance.
* Craving or a strong desire to urge to use a specific substance.

In the case that an individual no longer meets the criteria for a substance use disorder (became “clean and sober”), “in early remission”, “in sustained remission,” “on maintenance therapy,” or “in a controlled environment” may be added to the diagnosis. |
| Serious Mental Illness[[2]](#footnote-2) | A serious mental illness is defined as:* A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders);
* Diagnosable currently or within the past year;
* Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV);
* Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.
 |
| Developmental Disability[[3]](#footnote-3) | A severe, chronic disability of an individual that is:* Attributable to a mental or physical impairment or combination of mental and physical impairments;
* Is manifested before the individual attains age 22;
* Is likely to continue indefinitely;
* Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and,
* Reflects the need for a combination and sequence of special, interdisciplinary, or generic services, individualized reports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
 |
| Post-Traumatic Stress Disorder[[4]](#footnote-4) | Currently, diagnosis of PTSD is based on 8 criteria from the DSM-5.[4] * The first DSM criterion has 4 components, as follows:
	+ Directly experiencing the traumatic event(s)
	+ Witnessing, in person, the event(s) as it occurred to others
	+ Learning that the traumatic event(s) occurred to a close family member or friend
	+ Experiencing repeated or extreme exposure to aversive details of the traumatic event(s); this does not apply to exposure through media such as television, movies, or pictures
* The second criterion involves the persistent re-experiencing of the event in 1 of several ways:
	+ Thoughts or perception
	+ Images
	+ Dreams
	+ Illusions or hallucinations
	+ Dissociative flashback episodes
	+ Intense psychological distress or reactivity to cues that symbolize some aspect of the event
* The third criterion involves avoidance of stimuli that are associated with the trauma and numbing of general responsiveness, as determined by the presence of 1 or both of the following:
	+ Avoidance of thoughts, feelings, or conversations associated with the event
	+ Avoidance of people, places, or activities that may trigger recollections of the event
* The fourth criterion is 2 or more of the following symptoms of negative alterations in cognitions and mood associated with the traumatic event(s):
	+ Inability to remember an important aspect of the event(s)
	+ Persistent and exaggerated negative beliefs about oneself, others, or the world
	+ Persistent, distorted cognitions about the cause or consequences of the event(s)
	+ Persistent negative emotional state
	+ Markedly diminished interest or participation in significant activities
	+ Feelings of detachment or estrangement from others
	+ Persistent inability to experience positive emotions
* The fifth criterion is marked alterations in arousal and reactivity, as evidenced by 2 or more of the following:
	+ Irritable behavior and angry outbursts
	+ Reckless or self-destructive behavior
	+ Hypervigilance
	+ Exaggerated startle response
	+ Concentration problems
	+ Sleep disturbance
* The remaining 3 criteria are as follows:
	+ The duration of symptoms is more than 1 month
	+ The disturbance causes clinically significant distress or impairment in functioning
	+ The disturbance is not attributable to the physiological effects of a substance or other medical condition.
 |
| Cognitive Impairments resulting from brain injury[[5]](#footnote-5) | Cognitive deficits (impairments in thinking skills) may involve:* Changes in awareness of one's surroundings, attention to tasks, reasoning, problem solving, and executive functioning (e.g., goal setting, planning, initiating, self-awareness, self-monitoring, and evaluation).
* Although new learning is impacted by memory deficits, long-term memory for events and things that occurred before the injury, however, is generally unaffected (e.g., the person will remember names of friends and family).
* The person may have trouble starting tasks and setting goals to complete them. Planning and organizing a task is an effort, and it is difficult to self-evaluate work.
* The individual often seems disorganized and needs the assistance of family and friends.
* He or she also may have difficulty solving problems and may react impulsively (without thinking first) to situations.
 |
| Chronic Physical Illness or Disability | * A disease, condition or disability lasting 3 months or more.
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| **APPENDIX C: THIRD PARTY VERIFICATION FORM FOR HOMELESSNESS/CHRONIC HOMELESSNESS** |

**For Agencies:** You may choose to copy and paste this content onto your agency’s letterhead.

**For Non-Agencies:** Please complete and submit information, using this form.

**APPLICANT’S NAME (FIRST, LAST):**

|  |  |
| --- | --- |
|  |  |

**DESCRIPTION OF HOMELESSNESS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Homeless Occasion | Start date of homeless occasion | End date of homeless occasion | Number of days break between homeless occasion | Location of applicant during homeless occasion | Location of applicant prior to homeless occasion |
| 1 |  |  | N/A |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
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| 7 |  |  |  |  |  |
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| 10 |  |  |  |  |  |

**TOTAL MONTHS OF HOMELESSNESS ACROSS HOMELESS OCCASIONS:**

|  |
| --- |
|  |

**AGENCY OR PERSON COMPLETING THIRD-PARTY HOMELESS VERIFICATION:**

|  |  |
| --- | --- |
| **Name of Person:** |  |
| **Agency:** |  |
| **Address:** |  |
| **Phone:** |  |
| **Email:** |  |

**DESCRIBE RELATIONSHIP OF THIRD-PARTY TO APPLICANT:** (Indicate why you are an adequate source to verify their period(s) of homelessness.)

|  |
| --- |
|  |

**SIGNATURE OF THIRD-PARTY DATE**

|  |
| --- |
| **APPENDIX D: SELF-CERTIFICATION FORM FOR HOMELESSNESS/CHRONIC HOMELESSNESS** |

**NOTE: COMPLETE ONLY IF THIRD PARTY VERIFICATION IS UNAVAILABLE**

Instructions: This template for a self-statement certification may be used when a person experiencing homelessness applying to a program serving chronically homeless persons lacks connections with service providers to complete a third party verification of a history of chronic homelessness. This self-statement should be maintained in the client’s file.

**I certify that I was homeless** *(that is sleeping in a place not meant for human habitation such as living on the streets OR in an emergency shelter)* **during the following period(s) of time:**

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Between \_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ I lived at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What else would you like to share about your history?** (For example, “*I cannot remember the names of the places where I was living during the fall of 2004 but I believe that it was an emergency shelter. I have problems with my memory from that time due to an illness.”)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify that the above information is correct.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF APPLICANT DATE**

**I reviewed the above statement with the client.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF STAFF WITNESS ORGANIZATION DATE**

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| --- |
| **APPENDIX E: VERIFICATION OF DISABILITY FORM FOR CLINICALLY LICENSED PROFESSIONALS** |

**This form must be completed by a clinically licensed professional if the source for disability verification is not an approved document from the Social Security Administration.**

Instructions:

**Referral Source:** Please complete the top portion of the form above the line and give to a clinically licensed professional to complete the bottom.

**Clinical Professional:** Please complete the bottom portion of the form return to the referral source’s contact information provided directly below.

**RETURN FORM TO REFERRAL SOURCE AT:**

|  |  |
| --- | --- |
| Name: |  |
| Address/location to send form and supporting documentation: |  |

**SECTION ONE: TO BE COMPLETED BY REFERRAL SOURCE:**

**APPLICANT’S NAME (FIRST, LAST):**

|  |  |
| --- | --- |
|  |  |

**APPLICANT’S DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I acknowledge that I understand the purpose of this form is to verify that I have a disability for the purpose of meeting the eligibility requirements for Permanent Supportive Housing. I have given my consent to the clinically licensed professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (NAME OF PROFESSIONAL) completing the second section below to release all relevant information related to my disability in order to verify that I meet the criteria.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF APPLICANT DATE**

**SECTION TWO: TO BE COMPLETED BY CLINICALLY LICENSED PROFESSIONAL:**

The applicant identified above is applying for Permanent Supportive Housing, which requires verification of a qualifying disability by a North Carolina clinically licensed professional with the knowledge and ability to diagnose and treat the disability identified. The disability must be long-continuing or of indefinite duration, substantially impeded the person's ability to live independently, and could be improved by more suitable housing.

**For Clinically Licensed Professional:**

By initialing and signing below, I acknowledge that I understand the purpose of this form is to verify that the applicant has a disability for the purpose of meeting the eligibility requirements for Permanent Supportive Housing. I also acknowledge that I meet the criteria listed above in order to complete this form and have completed all of the required entries to the best of my knowledge.

**Please initial by the following that you understand and have met the following criteria:**

|  |  |
| --- | --- |
|  | **Recognized NC Clinically Licensed Professional** (physician, psychiatrist, psychologist, registered nurse, licensed clinical social worker, or licensed professional counselor) |
|  | **Have knowledge and ability to diagnose AND treat disability identified.** |
|  | **Applicant has authorized me to verify their disability and release all relevant information in order to verify it.** |

**Please sign that you acknowledge the above statement and meet the criteria and provide your credentials and information below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF PROFESSIONAL DATE**

|  |  |
| --- | --- |
| Professional License Number: |  |
| Agency / Organization: |  |
| Phone: |  |
| Email: |  |
| Length of time worked with applicant: |  |

Disability Verification *(This section is to be completed by the Clinically Licensed Professional only.)*

**Please select Yes or No for the following:**

1. The disabling condition of the applicant is long-continuing or of indefinite duration, substantially impedes the person's ability to live independently, and could be improved by more suitable housing.
2. The person has the following disability (ies). **Please 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
3. Please provide code of diagnosis if applicable:

|  |  |  |
| --- | --- | --- |
| **DISABILITY** | **DIAGNOSIS CODE** | **SOURCE (DSM, etc.)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Please attach additional information to in order to verify disabling condition (physician progress note, comprehensive clinical assessment, etc.) and indicate which items you are attaching below:

|  |  |
| --- | --- |
| **NUMBER** | **ATTACHMENT DESCRIPTION** |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
| **5** |  |

1. American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author. [↑](#footnote-ref-1)
2. Substance Abuse and Mental Health Services Administration (SAMHSA) (1995) [↑](#footnote-ref-2)
3. Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002). [↑](#footnote-ref-3)
4. American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author. [↑](#footnote-ref-4)
5. “Traumatic Brain Injury (TBI)”. American Speech-Language Hearing Association (2015). [↑](#footnote-ref-5)