Certification of Chronic Homeless

This document may be used to analyze whether or not an individual or family meets the definition of chronic homeless based on 2CFR 91.5 and 24 CFR 578.3. Documentation must be attached to verify status.

Applicant Name and HMIS ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Applicant or head of household has the following disability check all that apply:

* A diagnosable substance abuse disorder of long duration that limits ability to live on own
* A mental health problem
* A developmental disability
* A chronic health problem
* A physical disability

**AND**

Has been literally homeless:

* For at least 12 months **or**
* On at least four separate occasions in the last 3 years with combined total of 12 months (*break between episodes ≥7 consecutive nights*) **or**
* Continuously unsheltered **or**
* Living in a shelter for the past 12 months **or**
* This is the 4th separate occurrence of this living situation in the past 3 years
* Living in institutional care facility <90 where they were chronic homeless at entry

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Start Date | End Date | Number of Days | Location of Stay | Documented? |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  |  |  |  | Yes/No |
|  | **Total Days** |  |  |  |

Based on this summary, I certify that the client: □is chronically homeless □is NOT chronically homeless

Staff Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_