VALLEY OPPORTUNITY COUNCIL

the Business of
Opportunity
Building.

35 Mt. Carmel Avenue, Chicopee, MA 01013
413.552.1554 • Fax: 413.552.1558

Stephen C. Huntley,
Executive Director

Community Action Agency
Serving Chicopee and Holyoke and Surrounding Communities

Energy Assistance
Nutrition
Early Education & Care
Youth Services
College Access
Adult Education
Senior Services
Housing
Money Management
Transportation
Preschool Enrichment Team

December 8, 2014

Valley Opportunity Council
Scattered Site Family Supportive Housing

Description of the Program:
VOC will provide scattered site permanent supportive housing for chronically homeless families. This program will serve 20 people in 8 units and will be for families who have had long shelter stays and are assessed as needing supportive housing in order to be able to exit shelter successfully.

Participants will receive regular case management to assist them in maintaining housing and working toward self-sufficiency. Families will each pay 30% of their income for rent.

Participant Demographic Information:
Participants must meet chronically homeless standards.
Adult participants must meet disabled status.
100% of participants should come directly from emergency shelters.
We are looking for families consisting of at least 1 adult and 1 child and of those:

- 8 should be Disabled Adults
- 12 should be accompanied Non-disabled children under age 18

Required Documents:
Verification of Chronic Homelessness
Verification of Disabled Status
Verification of Income

VOC Contact Person:
Jamie Chazan
Director of Programs
Phone: 413-552-1554 x701 115
Fax: 413-552-1558
jchazan@valleyopp.com

Western Massachusetts

network to end homelessness

3 County Continuum of Care

Hampden County Continuum of Care

Chronically Homeless Qualification Checklist

Instructions: This checklist is to be used for verification of chronically homeless status. It should be accompanied by supporting documentation of both disability and homelessness. These documents must be maintained in the client's file.

Client Name:_____

The HUD definition of a Chronically Homeless Individual or Family is an individual or family that is homeless and has a head of household with:

Part I. A Disabling Condition. *Check appropriate box(es):*

- ☐ A diagnosable substance abuse disorder
- ☐ A serious mental illness
- ☐ A developmental disability
- ☐ Post-traumatic stress disorder
- ☐ Cognitive impairments resulting from a brain injury
- ☐ Chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Part I is supported by a letter from a medical professional attesting to the presence of the condition.

- ☐ Yes
- ☐ No

Part II. Chronic Homelessness. Check ONE:

- ☐ Has been continuously homeless for a year or more.
- ☐ Has had four (4) episodes of homelessness in the last three (3) years.

Part II must be supported by Third Party Certification, which includes dates and locations of homelessness, from one or more of the following: *Check ALL that apply*

- ☐ Certification letter(s) from an emergency shelter for the homeless.
- ☐ Certification letter(s) from a homeless service provider or outreach worker.
- ☐ Certification letter(s) from any other health or human service provider.
- ☐ Certification Self-Statement signed by the client.

Staff Name: _____ Staff Title: _____

Organization: _____

Signature: _____ Date: _____

Western Massachusetts

network to end homelessness

3 County Continuum of Care

Hampden County Continuum of Care

Chronically Homeless Third Party Verification Form

Instructions: This form or similar may be completed by the certifying agency. This recommended template can be copied onto letterhead or recreated with the same content and printed on letterhead.

Certification

I certify that _____ stayed at _____
(Client's Name) (Facility/ Program Name)

for the following period of time:

(1) between: ____/____/____ and : ____/____/____

(2) between: ____/____/____ and : ____/____/____

(3) between: ____/____/____ and : ____/____/____

(4) between: ____/____/____ and : ____/____/____

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

_____

_____

_____

Before coming to this facility, the homeless person resided at _____.

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

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

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

Title: _____ Phone: _____

Western Massachusetts

network to end homelessness

3 County Continuum of Care

Hampden County Continuum of Care

Chronically Homeless Self-Statement Certification Form

Instructions: This template for a Self-Statement Certification may be used when a homeless person 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. It 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** living in a homeless emergency shelter during the following period(s) of time:

Between *Example*: Jan., 2009 and *Aug., 2009* I lived at *Worcester Shelter*

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 name of the place where I was living during the fall of 2010 but I believe that it was a homeless emergency shelter. I have problems with my memory due to an illness."*

_____

_____

_____

_____

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)

Western Massachusetts

network to end homelessness

3 County Continuum of Care

Hampden County Continuum of Care

Verification of Disability

Instructions: All participants in HUD-funded Permanent Supportive Housing programs and Chronic Homeless programs should have verification of their disabling condition. Documenting verification may be done in several ways, as noted below. Place this form and its attachments in the client's file.

Client Name: _____

Date: _____

Specify the method of verifying the disability:

☐ Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently.

Attach the certification. A sample is provided on the following page.

☐ Written verification from the Social Security Administration.

Attach the verification letter.

☐ The receipt of a disability check.

Attach a copy of the SSI/SSDI check.

☐ Intake staff-recorded observation of a disability that, no later than 45 days of the application for assistance, is confirmed and accompanied by evidence as specified above.

Enter the date that is 45 days from the application: _____ ***(mm/dd/yyyy)***

Western Massachusetts

network to end homelessness

3 County Continuum of Care

Hampden County Continuum of Care

Verification of Disability Form – to be completed by qualified professional

INSTRUCTIONS: A qualified professional with one of the following credentials—MD, DO, LCPC, LCSW, APRN-BC, NP—must complete this form. Sections 1, 2 and 3 of the form apply to:

Name DOB

SECTION 1: APPLIES TO INDIVIDUALS WITH PSYCHIATRIC DISABILITIES, CHRONIC SUBSTANCE ABUSE AND HIV/AIDS

The above named individual is an adult having a physical, mental, or emotional impairment that:

(a) is expected to be of long-continued and indefinite duration

AND

(b) substantially impedes the person's ability to live independently

AND

(c) is such that the person's ability to live independently could be improved by more suitable housing conditions.

If a, b, and c above are true then please check 'Yes', otherwise check 'No' ☐ YES ☐ NO

SECTION 2: APPLIES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

The above named individual is an adult with a chronic developmental disability which:

(a) is attributable to a mental and/or physical impairment or combination mental and physical impairments; **AND**
(b) was manifested before the person attained age 22; **AND**
(c) is likely to continue indefinitely; **AND**
(d) results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and 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 which are of lifelong, or extended duration and are individually planned and coordinated.

If a, b, c, d, and e are true then please check 'Yes', otherwise check 'No' ☐ YES ☐ NO

Continue to back of page.→

Western Massachusetts

network to end homelessness

3 County Continuum of Care

Hampden County Continuum of Care

Income Verification Form

Name of Applicant: _____

Please complete either Part I or Part II

I. If applicant household has source(s) of income

Anyone that is/will be living in the household that is currently receiving income (employment, SSI, SSDI, OWF/TANF, retirement, Social Security, etc.), must complete this section.

I/we certify that as of _____ (mm/dd/yyyy), my source(s) of income are as follows:

_____ $_____ _____

Source Amount Income for which household member

_____ $_____ _____

Source Amount Income for which household member

Please provide income documentation for each source of income (statement from the source of income - SSI, SSDI, Social Security, EA/TANF, and/or copy of last three months of payroll/benefit checks). Continue on back if necessary.

II. If applicant household does not have a source of income

If there is currently no household income, please complete this section.

I/we certify that as of _____ (mm/dd/yyyy), I/we have no source of income.

By signing this document, I/we certify that the above information is true and accurate to the best of my knowledge. I/we understand that the agency will be verifying this information.

Failure to provide correct information could lead to ineligibility for assistance from the program.

Must be signed by all adult household members and adolescents who are employed.

_____ _____

Signature Date

_____ _____

Signature Date

_____ _____

Signature Date