



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

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:

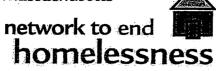
Jamie Chazan

Director of Programs

Phone: 413-552-1554 x701 115

Fax: 413-552-1558

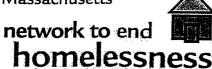
jchazan@valleyopp.com



3 County Continuum of Care Hampden County Continuum of Care

Chronically Homeless Qualification Checklist

be acc	ons: This checklist is to be used for verification of chronically homeless status. It sho npanied by supporting documentation of both disability and homelessness. These nts must be maintained in the client's file.	ould
Client I	ime:	_
	definition of a Chronically Homeless Individual or Family is an individual or family tess and has a head of household with:	that
Part I.	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 m of these conditions.	ore
	art I is supported by a letter from a medical professional attesting to the presence one condition. Yes No	of
Part II.	thronic Homelessness. Check ONE: Has been continuously homeless for a year or more. Has had <u>four (4)</u> episodes of homelessness in the last <u>three (3)</u> years.	
	art II must be supported by Third Party Certification, which includes dates and location from 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.	ions
Staff N	ne:Staff Title:	
Organi	tion:	
Sianatı	Date:	



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) for the following period of time:	(Facility/ Program Name)				
(1) between:/	and :/				
(2) between:/	and :/				
(3) between:/	_ and :/				
(4) between:/	_ and :/				
Additional detail about the client's episodes					
Before coming to this facility, the homeles	s person resided at e following types of facilities/programs:				
Emergency Shelter	Correctional Facility				
Transitional Housing	Substance Abuse Facility				
Permanent Housing	Mental Health Institution				
Medical Institution	Other:				
Signature:(Signature of Facility Staff)	Date:				
Title:	Phone:				



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:

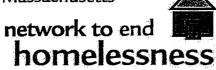
Between <i>Example</i> : Jan., 2009	and <u>Aug., 2009</u>	I lived at <u>Worcester Shelter</u>
Between	and	I lived at
Between	and	I lived at
Between	and	I lived at
Between	and	I lived at
Between	and	I lived at
	iving during the fall of 201	or example, "I cannot remember the O but I believe that it was a homeless to an illness."
I certify that the above informa	tion is correct.	
(Signature of Client)		(Date)
I reviewed the above statemen	t with the client.	
		·
(Signature of Staff Witness) (Organization	tion)	(Date)



3 County Continuum of Care Hampden County Continuum of Care

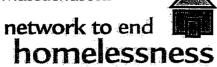
	Verification of Disability
Chi ver	etructions: All participants in HUD-funded Permanent Supportive Housing programs and ronic Homeless programs should have verification of their disabling condition. Documenting ification may be done in several ways, as noted below. Place this form and its attachments in a client's file.
LITC	; cheft 3 file.
Clie	ent Name:
Da	i
υa	<u> </u>
Sp	ecify the method of verifying the disability:
tre cor	Written verification of the disability from a professional licensed by the state to diagnose and at the disability and his or her certification that the disability is expected to be longnationing or of indefinite duration and substantially impedes the individual's ability to live dependently.
	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 assistance, is confirmed and accompanied by evidence as specified above.

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



3 County Continuum of Care Hampden County Continuum of Care

Verification of Disability Form	- to be completed by qualified professional
	with one of the following credentials—MD, DO, LCPC, is form. Sections 1, 2 and 3 of the form apply to:
Name	DOB
SECTION 1: APPLIES TO INDIVIDUALS	S WITH PSYCHIATRIC DISABILITIES, CHRONIC
SUBSTANCE ABUSE AND HIV/AIDS	
The above named individual is an adult h	naving a physical, mental, or emotional impairment that:
(a) is expected to be of long-continued a	and indefinite duration AND
(b) substantially impedes the person's ab	oility to live independently AND
(c) is such that the person's ability to live housing conditions.	ve independently could be improved by more suitable
If a, b, and c above are true then please c	check 'Yes', otherwise check 'No' 🔲 YES 🔲 NO
	; ;
SECTION 2: APPLIES TO INDIVIDUALS	S WITH DEVELOPMENTAL DISABILITIES
The above named individual is an adult w	with a chronic developmental disability which:
(a) is attributable to a mental and physical impairments; AND	d/or physical impairment or combination mental and
(b) was manifested before the persor	-
(c) is likely to continue indefinitely; A	
major life activity: self-care; rece	imitations in three (3) or more of the following areas or eptive and expressive language; learning; mobility; self- ent living; and economic self-sufficiency; AND
(e) reflects the person's need for a c	combination and sequence of special interdisciplinary o services which are of lifelong, or extended duration and
If a, b, c, d, and e are true then please ch	neck 'Yes', otherwise check 'No'



3 County Continuum of Care Hampden County Continuum of Care

1	Income Verific	ation Form	
Name of Applicant:			
Please complete either Part I	or Part II		
	in the household tha	t is currently receiving income c.), must complete this section.	
I/we certify that as of	(mm/dd/yyy	y), my source(s) of income are a	s follows:
	<u> </u>		· · · · · · · · · · · · · · · · · · ·
Source	Amount	Income for which household r	member
	<u> </u>		
Source		Income for which household i	
checks). Continue on back if II. If applicant household d If there is currently no house	oes not have a source		
I/we certify that as of	(mm/dd/yyyy),	I/we have no source of income.	
		pove information is true and a pency will be verifying this inform	
Failure to provide correct inf	ormation could lead to	ineligibility for assistance from	the program.
Must be signed by all adult h	nousehold members ar	nd adolescents who are employ	ed.
Signature	·	Date	
Signature		Date	
Signature		 Date	