 **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](https://www.hudexchange.info/).

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 3.17) is not sufficient.

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.

***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** |
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| *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:** |
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| **Part 2: Housing History** |
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|  | **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* |
|  | **Chronic Homelessness Documentation Checklist - Page 2 of 4 (Not including Attachments)** |

| **Part 3: Disability Status** |
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| *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:** |
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| **Part 4: Staff and Client Certifications** |

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| **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:** |
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| **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.* |
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| **Staff Name: (Printed)** | **Staff Signature:** | **Date:** |
| --- | --- | --- |
| **Staff Role:** | **Agency:** |  |

| **Notes:** |
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