RRH to PSH Transfer Packet

Please fill out the complete Chronic Homeless Verification Packet for your participant and upload it with your transfer request form. The packet has two parts, and both are **mandatory** for a transfer request to be approved.

- **Part 1:** RRH to PSH Housing Needs Assessment
- **Part 2:** Chronic Homelessness Verification

Part 1: RRH to PSH Housing Needs Assessment

This tool assesses the need for support, not just eligibility. We are identifying participants who cannot maintain housing—even with a subsidy—without intensive, long-term wraparound services.

How to prepare:

- **Observation based:** Use your knowledge of the client's history (missed rent, neighbor conflicts, hospitalization) to assess them objectively.
- **Collaborative:** Walk through the questions with the participant. Use this as a conversation starter about their needs and worries regarding housing stability.
- **Future focused:** Focus on past behaviors as predictors of future needs, rather than the participant's intentions.

Interpreting the stages: Rating a participant at any stage does not approve or reject them for PSH. These scores are designed to help guide your planning and decision-making.

Stage 1: Stable (Light or No support)	• **What it means:** The participant may no longer require the intensive wraparound services of PSH, even if financial barriers persist. • **Suggested next steps:** Consider applying for Housing Choice Vouchers (HCV), exploring shared housing options, developing a plan to increase household income, and exploring safe and appropriate family reunification options when desired by the participant and clinically or legally appropriate.
Stage 2: Moderate Risk (Moderate support)	• **What it means**: The participant requires continued case management to maintain housing stability, but may not need a permanent PSH placement to remain stably housed. • **Suggested next steps:** Consider target interventions based on the specific barrier. Assess eligibility for SSI/SSDI/SNAP; connect with community mental health or harm reduction specialists; identify organizations that can provide long-term, non-intensive life-skills support.
Stage 3: High Risk (High level of support)	• **What it means:** Scores in this range indicate significant barriers to independent living, such as severe disability or the effects of long-term chronic homelessness. • **Suggested next steps:** Evaluate suitability for PSH Transfer or need for higher level care (e.g., nursing home, mental health care facility).

Part 2: Chronic Homelessness Verification

To be eligible for a PSH transfer, the participant must meet HUD eligibility criteria. Use part 2 of the Chronic Homeless Verification Packet to verify your participant's eligibility.

Rule 1: Disability Verification (Part 1) - The participant must have a qualifying disability (long-continuing, impedes independence, improved by housing) that is verified in one of the formats below:

- **Attachment I:** Verification signed by a licensed medical professional (LCSW, MD, etc.) **OR**
- **SSA Disability Award Letter:** Include a copy of the letter or disability checks in the packet **OR**
- **Attachment II:** Temporary 45-day third-party documentation to use while you're working on obtaining official verification of disability (e.g., award letter, verification signed by licensed medical professional). Verification must be obtained within **45 days of enrollment.**

Rule 2: Homelessness Verification (Part 2) - The participant must meet the Chronic Homelessness timeline criteria:

- Option A (Continuous): Homeless continuously for at least 12 months.
- Option B (Episodic): At least 4 separate occasions in the last 3 years that total 12+ months.
  - *Note on Breaks*: A break is 7+ consecutive nights in housing (e.g., staying with family or friends, couch-surfing, paying for motel or hotel) OR 90+ days in an institution (e.g., jail, hospital, mental health or substance use treatment facility).

<u>Verification methods:</u>

- **HMIS Record**: attach a screenshot of your participant's record
- **Attachment III**: Third-party verification (shelter staff, outreach worker, businesses, community member).
- **Attachment IV**: Self-certification (should be used only when 3rd party cannot be obtained)

Important reminders to keep in mind when building the chronic homelessness timeline

- Homelessness must be verified for the period immediately prior to program entry.
- Verification should cover every month in the timeline, with no gaps in documentation. Each month must be documented, either as part of a homeless episode or as a break in homelessness.
- Only one day in the month is enough to verify a homelessness episode for the entire month.
- Breaks must be recorded through the self-certification attachment.
- Please note HUD guidance released in November 2016 regarding homeless documentation:
  - **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.
  - **25%** of households served can use self-certification as documentation for any and all months.

Part 1: RRH to PSH Housing Needs Assessment

Use this assessment whenever a participant is requesting, considering, or being considered for a transfer to PSH. The tool is intended to support case managers in determining whether a transfer to PSH is appropriate at this time for the participant.

Applicant Name:	**HMIS #:**
Agency staff:	
Agency:	**Staff E-mail:**

Instructions: For each criterion (each row), determine which stage (1 = low risk, 2 = moderate risk, 3 = high risk) best describes the participant. Enter the corresponding stage number (1, 2, or 3) in the last column. Select only one stage per row.

Section 1: Housing Exit Plan

Criteria	Stage 1 (Stable / Low Barrier)	Stage 2 (At Risk / Moderate Barrier)	Stage 3 (Crisis / High Barrier)	Scale (1-3)
Family/Friend Reunification	Participant has an option to live with family or friends that is either safe/stable, OR exist with minor concerns that can be managed.	Previous attempts to live with family or friends have been unsuccessful due to conflict or an unstable living situation.	No realistic housing options with family or friends are available, OR past attempts were harmful to safety/well-being.	
Current Housing Waitlists	Participant is eligible and currently on at least one housing waitlist (e.g., CHA, SRN, other public housing authorities)	Participant is eligible to be placed on a waitlist, and taking clear steps to sign up for housing opportunities.	Participant is ineligible or faces major barriers (e.g., program restrictions, mental health crisis) preventing them from applying for housing waitlists.	
Supportive Services Needed to Maintain Housing	Does not need ongoing service provider support. They already have support provided by family and/or community resources.	Participant either needs light-touch housing-focused case management or support from other programs to successfully maintain their housing.	Needs intensive, frequent, and hands-on support. Without this, the participant is at high risk of losing housing.	

Section 2: Housing stability

Criteria	Stage 1 (Stable / Low Barrier)	Stage 2 (At Risk / Moderate Barrier)	Stage 3 (Crisis / High Barrier)	Scale (1-3)
Housing Costs	Pays rent/utilities consistently or most months. If issues/missed payments arise, participant works with staff to resolve them quickly.	Payments are frequently missed. Engagement to address issues is limited and requires significant staff outreach.	Payments are not made. Current strategies have failed to resolve arrears. Systemic or behavioral barriers prevent resource use.	
**Note: For participants who have a third-party who pays the rent for them, they should be placed at stage 1.*				
Lease Violations	No violations, or 1–2 minor verbal warnings/informal complaints. Issues are resolved quickly by the participant or light case management.	Formal written violations or repeated complaints. Landlord relationship is strained but managed with support from case management.	Frequent severe violations putting participant at imminent risk of eviction.	

Section 3: Supportive Services and Resources

Criteria	Stage 1 (Stable / Low Barrier)	Stage 2 (At Risk / Moderate Barrier)	Stage 3 (Crisis / High Barrier)	Scale (1-3)
Connection to Community	Participant is well-connected to community supports that can help sustain stable housing (e.g., family, friends, faith organizations) OR has a few connections and is open to developing more.	Support network is very limited. Requires active staff guidance to identify and build new connections.	No support network outside of the program. Significant barriers prevent building connections even with assistance.	
Crisis Intervention	Crises such as mental health episodes, overdoses, altercations are rare or of low severity. Participant manages stressors independently or with light coaching.	Crises occur frequently and negatively impact housing stability. Requires active staff intervention (e.g., mediation, on-site response).	Crises are regular and severe. Continuous instability impacts participants' ability to live independently. If participants are not able to live independently, other housing options may need to be explored.	
Life Skills	Manages daily life skills (hygiene, cooking, medication) independently, or with rare external support/ reminders.	Needs occasional, direct assistance to complete many daily tasks essential for maintaining housing stability.	Requires intensive, often weekly, assistance to meet most basic personal care and safety needs.	

Section 4: Health

Criteria	Stage 1 (Stable / Low Barrier)	Stage 2 (At Risk / Moderate Barrier)	Stage 3 (Crisis / High Barrier)	Scale (1-3)
Mental Health	Attends most mental health appointments OR mental health support is not needed to maintain housing stability.	Attends less than half of scheduled appointments, but mental health poses a small risk to their ability to maintain housing.	Requires services but has had very limited or no contact with mental health services since entering the program, resulting in high risk in their ability to maintain housing.	
Primary Health Care Use	Participant is connected to care or can independently navigate health care services.	Participant is connected to care, but needs assistance with navigating health care services (insurance applications, appointment reminders).	Participant is not connected. Needs deep support to navigate health care system OR is not engaged in health care.	
Harm Reduction	Has adopted goals to reduce risky behavior and taken actions to achieve them OR does not engage in risky behaviors that require harm reduction.	Acknowledges behavior may be risky and is contemplating harm reduction goals.	Has not identified behaviors as having potential for harm.	

Section 5: Income and Benefits

Criteria	Stage 1 (Stable / Low Barrier)	Stage 2 (At Risk / Moderate Barrier)	Stage 3 (Crisis / High Barrier)	Scale (1-3)
Income Consistency	Has had stable/consistent cash income for the last 12 months.	Has cash income, but it is not stable/consistent.	Does not have stable/consistent cash income, and obtaining one appears unlikely in the near future.	
Employment & Sufficiency	Earned income is sufficient/stable, OR participant has recently secured income OR is actively seeking work with only temporary barriers.	Relies on sporadic or fixed income that does not cover basic needs. Faces moderate barriers (health, transportation, work history gaps).	No stable earned income. Significant functional/systemic barriers (disability, legal status) prevent workforce participation.	
Benefits	Receives all eligible benefits or has recently been approved. Manages requirements with minimal reminders.	Receives some benefits, but not all OR applied and awaiting decision. May require active assistance to gather docs/attend appointments to avoid denial.	Appears eligible but not connected. Complex barriers (mental health, cognition) prevent application without intensive support, OR participant is not eligible for benefits.	

Action Plan & Next Steps

1. Based on the assessment, please **rank (1-4)** below the goals for this participant

1 = Highest priority 4 = Lowest priority

	Living with family or friends
	Deeply Affordable Housing/ FMR Unit Search (Housing waitlists, moving-on program, partner landlords, co-living, or apartment sharing)
	Transfer Referral to PSH (High barriers, disability confirmed and can only successfully maintain housing in PSH)
	Intense Care Search (e.g., nursing home, mental health institution or housing)

2. Does the participant want to continue receiving supportive services? □ Yes □ No

3. Would the participant accept an SRO unit? □ Yes ■ No

4. If not, why is the participant rejecting an SRO Efficiency unit? Please check all that apply

□ Unit size/space constraints
□ Unit accessibility problems
□ Building safety rules: monitored entry
□ Building safety rules: curfews
□ Building guest policies
□ Building pet policies
□ Past experiences in a similar setting

Other reason(s) not listed above (please describe):

Staff Signature: _____Date: _____

Part 2: Chronic Homelessness Verification

The next two pages should be completed by agency staff

Applicant Name:	
Agency:	
Agency Staff:	
Staff Email:	**Staff Phone #:**
□ HMIS ID: _____ □ ICarol ID (If referred from a DV program): _____ □ Applicant has requested not to be entered into HMIS	
Household Size: □ Family | □ Single | □ Couple	

Qualifying Disability Criteria (Must check all): I certify that the applicant's disability is expected to:

□ Be of long-continuing or indefinite duration;

□ Substantially impede the ability to live independently; AND

□ Be improved by the provision of suitable housing.

To proceed filling out the packet, all boxes above must be checked.

Part 1: Disability Verification

1A. Diagnosis of Disability: Applicant or head of household has one or more of the following diagnosed disabilities:

□ Mental health disorder

□ Substance use disorder

□ Co-occurring mental health and substance use disorder

□ HIV/AIDS

□ Physical disability

□ Developmental disability

□ Other: _____

1B. Diagnosis of Disability Documentation (choose one of the options below):

□ Written verification from a professional licensed by the state to diagnose and treat the disability

[Use Attachment I]

□ Written verification from the Social Security Administration (e.g., Disability Award Letter, copies of disability check) **[Attach document to packet]**

□ Outreach Worker observation confirmed by a temporary Certification of Disability form. Verification must be obtained within 45 days of enrollment. **[Use Attachment II]**

Part 2: Evidence of Current & Long-term Homelessness

How to fill out the Chronic Homelessness Timeline:

- **Chronological Order:** Start with the most recent episode in the first row and work backwards
- **Duration**: At least 12 months within the last 3 years must be verified
- **Record Breaks**: A break is 7+ consecutive nights in housing (staying in friends or family house, hotel, rental, etc.) OR 90+ days in an institutional setting (e.g., jail, hospital, etc.)
- **Specific for Transfer Participants**: The first row should reflect the homeless status at the time of current project entry (no need to list current housing)

Eligibility Pathways - Check the box below that best describes your applicant's homeless history:

☐ A. Continuous: Homeless continuously for at least 12 months.

☐ B. Episodic: At least 4 separate occasions in the last 3 years, totaling at least 12 months.

Episode or Break	Start Date	End Date	# Months Verified	Homeless Situation (when possible, please include location)	Verification Type		
					HMIS	3rd Party	Self-Certification
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
☐ Episode ☐ Break					☐	☐	☐
Total number of months for homelessness episodes				**Important note:** A minimum of 12 months of homelessness is required for chronic homelessness verification			

Staff Name:	**Date:**
Signature:	

ATTACHMENT I - VERIFICATION OF DISABILITY

Verification of Disability for Permanent Supportive Housing (PSH)

What is this form?

You are being asked to complete the attached Verification of Disability Form for your patient listed in Section 1 on the next page.

This form is used by local housing programs to determine whether an applicant meets the disability requirement for Permanent Supportive Housing (PSH)[1] and related housing resources. This is not a Social Security (SSDI/SSI) disability form and not an evaluation of work capacity. It will not be used to decide if the person can work or is eligible for income benefits.

What is your role as a licensed medical provider?

Your role in this document is to confirm that the individual has a qualifying, long-term medical, mental health, or substance use condition and that this condition affects their ability to live independently and maintain stable housing without support.

The information you provide will be used to verify eligibility for PSH and similar housing programs.

What are you being asked to certify?

In Section 2 of the Verification of Disability, please:

- **Confirm the diagnosis/condition:** Check the disability descriptions that accurately reflect the patient's condition.
- **Confirm the disability type:** Select the primary disability category (or categories) that best describes the patient.
- **Confirm your credentials:** Complete the box that reflects your professional credential.

Important Reminders:

- You should **only** verify conditions that you are **licensed** to treat and diagnose.
- Information will be kept **confidential** and used only for **eligibility** and **care coordination**, consistent with applicable privacy laws.
- Provide only the information requested on the form. There is **no need** to share **detailed medical records** or information beyond what is asked.

[1]**Permanent Supportive Housing (PSH)** is long-term, affordable housing combined with ongoing support services (such as case management, behavioral health care, and linkage to medical treatment) for people who are homeless or at risk of homelessness and who have a long-term disability that substantially interferes with their ability to live independently without support.

ATTACHMENT I - VERIFICATION OF DISABILITY

Verification of Disability for Permanent Supportive Housing (PSH)

Section 1: To be completed by agency

Applicant Name:	
Agency:	**Agency Address:**
Agency Contact Staff:	
Staff email:	**Staff Phone #:**

Client Authorization for Release of Information

I, _____ (Applicant Name), authorize the release of information requested in this form for the purpose of verifying my eligibility for housing assistance and related services.

Applicant Signature: _____Date: _____

Section 2: To be completed by licensed medical professional

Please select all that apply:

☐A disability that meets the Social Security act definition[1]: a medically determinable physical or mental impairment that prevents substantial gainful activity and has lasted, or is expected to last, at least 12 months.

☐A physical, mental, or emotional impairment that is long-term or of indefinite duration, substantially impedes the individual's ability to live independently, and is of a nature that this ability could improve with more suitable housing conditions.

☐A developmental disability, as defined in federal law[2], meaning a severe, chronic disability attributable to a mental or physical impairment (or a combination of both).

☐The disease of acquired immunodeficiency syndrome (AIDS) or any condition resulting from the virus that causes AIDS. [To be completed by licensed medical professional]

Disability information - please select all that apply:

☐Mental health disorder
☐Substance use disorder
☐HIV/AIDS
☐Physical disability
☐Developmental disability
☐Co-occurring mental health and substance use disorder

Credential - please check the appropriate box:

☐Psychiatrist
☐Physician
☐Physician's assistant
☐Nurse practitioner
☐LCSW
☐LCPC
☐CNP
☐Psychologist
☐CADC

Licensed Professional Name:	
License #:	**Phone #:**
Practice Name:	**Agency Address:**
Signature:	**Date:**

[1] Section 223(d) of the Social Security Act
[2] Section 102(8a) of the Developmental Disabilities Assistance and Bill of Rights Act

ATTACHMENT II: THIRD-PARTY TEMPORARY VERIFICATION OF DISABILITY

Only complete this form if you do not have disability documentation, but are working to obtain it

Section 1: To be completed by agency	
Applicant Name:	**HMIS #:**
Agency:	**Agency Address:**
Agency Contact Staff:	
Staff Email:	**Staff Phone #:**

Please check ALL the boxes below before signing:

I understand and acknowledge that:

□ Based on my professional knowledge and/or credible information available to me, the participant named above has a disability that is expected to be of a long continued and indefinite duration, and substantially impedes their ability to live independently.

□ This third-party certification **does not replace** standard, required documentation of disability (e.g., medical records, Social Security Administration documentation, or verification by a licensed professional).

□ **No later than 45 days after the participant's enrollment**, the program must obtain acceptable documentation of disability and place it in the participant's file.

□ This form is **temporary** and may not be used to support program eligibility beyond the 45-day period after enrollment if required documentation is not obtained. In such cases, the case must be reviewed according to program policies and applicable regulations.

Section 2: Certification & Signature	

I certify that the information provided on this form is true and complete to the best of my knowledge and belief.

Staff Name:	**Date:**
Staff Signature:	

ATTACHMENT III: THIRD-PARTY HOMELESSNESS VERIFICATION

Section 1: To be completed by agency and applicant

Applicant Name:	
Agency:	**Agency Staff:**
Staff Email:	**Staff Phone #:**

Client Authorization for Release of Information

I, _____ (Applicant Name), authorize the release of information requested in this form for the purpose of verifying my eligibility for housing assistance and related services.

Applicant Signature: _____Date: _____

Housing provider is seeking verification for the following occasions of homelessness:

(1) Between_____ and_____

(2) Between_____ and_____

(3) Between_____ and_____

Section 2: To be completed by the third-party verifier

Verifier's Name:	
Phone #:	**Email:**
Affiliation – Select all that may apply: ☐Street Outreach Team ☐Emergency Shelter Staff ☐Medical / Mental Health Provider / Institution ☐Law Enforcement / Corrections	☐Faith-Based Organization ☐Case Manager / Social Worker ☐Community Member ☐Service provider ☐Other: _____

List below occasions when you directly observed or have records confirming the participant's homelessness.

Start Date	End Date	Location Type	Homeless Situation (when possible, please include location)
		□ Emergency Shelter □ Institutional care facility* □ Place not meant for human habitation**	
		□ Emergency Shelter □ Institutional care facility □ Place not meant for human habitation	
		□ Emergency Shelter □ Institutional care facility □ Place not meant for human habitation	

I certify that I have either personally observed the participant residing in the locations described above or have access to agency records that verify the participant's homeless status.

Signature of Verifier: _____Date: _____

*A jail, substance abuse or mental health treatment facility, hospital, or other similar facility; stay must be less than 90 days

**Place not designated for or ordinarily used as regular sleeping accommodation e.g., car, park, abandoned building, bus/train station, encampment.

ATTACHMENT IV: CHRONIC HOMELESSNESS SELF-CERTIFICATION

To be completed by the applicant, with support from agency

Please use this form to describe your past housing history, for example:

- **An episode**: Location and period when you were experiencing homelessness, for example staying in a shelter, living in a car, encampment, abandoned building, tent, etc.
- **A break:** A period when you had a place to stay for more than 7 nights, for example couch-surfing, staying with a friend or a family member, staying in a hotel or motel paid by yourself.
- **A break:** A period when you were admitted to an institution such as a hospital, medical care facility or a jail for more than 90 days.

Applicant Name:	**Date of Birth:**
Applicant Email:	**Applicant Phone #:**

Episode or Break	Start Date	End Date	# of months	Description of livingconditions (car, friends or family house, in a tent, in the open, hospital etc.):	Location (address, name of public space, street name, landmark, etc.):
□ Episode □ Break					
□ Episode □ Break					
□ Episode □ Break					
□ Episode □ Break					
□ Episode □ Break					
□ Episode □ Break					
□ Episode □ Break					
Total months of homelessness					

To the best of my knowledge and ability, I certify that all the information provided in this document is true and complete.	
***Applicant Signature**:*	***Date:***
Staff Signature:	***Date:***