

## Coordinated Entry Assessment Part 5 – Eligibility Verifications

### PARTICIPANT CONTACT INFORMATION

Participant Name \_\_\_\_\_

HMIS # \_\_\_\_\_

Current living arrangements \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State, Zip \_\_\_\_\_

Primary Phone (\_\_\_\_\_) \_\_\_\_\_

Secondary Phone (\_\_\_\_\_) \_\_\_\_\_

Best way to find/contact participant \_\_\_\_\_

\_\_\_\_\_

### SENDING AGENCY INFORMATION

AGENCY NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Agency Contact: \_\_\_\_\_

*Phone:* \_\_\_\_\_

*Fax:* \_\_\_\_\_

*Email:* \_\_\_\_\_

### Eligibility Summary Checklist

Literally Homeless: Category   \_\_1\_\_   \_\_4\_\_

Homelessness History:   \_\_<12mos\_\_   \_\_12+ Continuous\_\_   \_\_12+ 4 Episodes/3 years\_\_   \_\_12+ but < 4 episodes\_\_

Disability Verification:       \_\_Yes\_\_       \_\_N/A\_\_

Veteran Status Verification:   \_\_Yes\_\_       \_\_N/A\_\_

Income Verification:       \_\_Yes\_\_       \_\_N/A\_\_

Complete ID Docs:       \_\_Yes\_\_       \_\_No\_\_

Other, please specify: \_\_\_\_\_

# Coordinated Entry Assessment Part 5A - Homelessness History Verification:

Client Name: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

HMIS #: \_\_\_\_\_

Episode 1: Most Recent Episode (this episode is entered into HMIS on the Chronic Homeless Assessment)			
(a1) Month and Year this episode started  In HMIS this is "Date Homelessness Started"	(a2) Month and Year this episode ended	(a3) How many months or days this episode lasted  <input type="checkbox"/> Months <input type="checkbox"/> Days  In HMIS this is "Length of Stay in Previous Place"	(a4) Location  In HMIS this is "Residence Prior to Project Entry"
Notes  <b>Each month reported in (a3) must have supporting documentation. See attached worksheet.</b>			

**Break between episode 1 and 2**

(b1) Start Date (MM/YY):

(b2) End Date (MM/YY):

(b3) Location/Notes:

Episode 2			
(c1) Month and Year this episode started	(c2) Month and Year this episode ended	(c3) How many months this episode lasted	(c4) Location
Notes  <b>Each month reported in (a3) must have supporting documentation. See attached worksheet.</b>			

**Break between episode 2 and 3**

(d1) Start Date (MM/YY):

(d2) End Date (MM/YY):

(d3) Location/Notes:

Episode 3			
(e1) Month and Year this episode started	(e2) Month and Year this episode ended	(e3) How many months this episode lasted	(e4) Location
Notes  <b>Each month reported in (e3) must have supporting documentation. See attached worksheet.</b>			

**Break between episode 3 and 4**

(f1) Start Date (MM/YY):

(f2) End Date (MM/YY):

(f3) Location/Notes:

Episode 4			
(g1) Month and Year this episode started	(g2) Month and Year this episode ended	(g3) How many months this episode lasted	(g4) Location
Notes  <b>Each month reported in (g3) must have supporting documentation. See attached worksheet.</b>			

**Break between episode 4 and 5**

(f1) Start Date (MM/YY):

(f2) End Date (MM/YY):

(f3) Location/Notes:

Totals			<i>More episodes on back</i>	
(i1) Earliest Start Date (from g1):  MM/YY	(i2) Most recent End Date (from a2)  MM/YY	Time between i1 and i2 must be less than or equal to 3 years.	(i3) How many total episodes have you filled out above?  In HMIS this is "Number of times homeless..."	(i4) Total Months  =a3+c3+e3+g3+n3+p3+r3+t3 In HMIS this is "Total Number of Months Homeless..."

*For additional episodes:*

Episode 5			
(n1) Month and Year this episode started	(n2) Month and Year this episode ended	(n3) How many months this episode lasted	(n4) Location
Notes			
Each month reported in (n3) must have supporting documentation. See attached worksheet			

**Break between episode 5 and 6**

(o1) Start Date (MM/YY):                      (o2) End Date (MM/YY):                      (o3) Location/Notes:

Episode 6			
(p1) Month and Year this episode started	(p2) Month and Year this episode ended	(p3) How many months this episode lasted	(p4) Location
Notes			
Each month reported in (p3) must have supporting documentation. See attached worksheet			

**Break between episode 6 and 7**

(q1) Start Date (MM/YY):                      (q2) End Date (MM/YY):                      (q3) Location/Notes:

Episode 7			
(r1) Month and Year this episode started	(r2) Month and Year this episode ended	(r3) How many months this episode lasted	(r4) Location
Notes			
Each month reported in (r3) must have supporting documentation. See attached worksheet			

**Break between episode 7 and 8**

(s1) Start Date (MM/YY):                      (s2) End Date (MM/YY):                      (s3) Location/Notes:

Episode 8			
(t1) Month and Year this episode started	(t2) Month and Year this episode ended	(t3) How many months this episode lasted	(t4) Location
Notes			
Each month reported in (t3) must have supporting documentation. See attached worksheet			

**Client Housing History Documentation for HMIS | Each month of homelessness on the Client Homeless History must be documented**

	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)											
Location	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)	Streets Shelter Safe Have Inst. (<90 days)
Check all that Apply												
Doc. Type	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database	HMIS Obsv. By Outreach Comp. Database
Check One  (Except SelfCert. select both)	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. Staff Doc. of Situation Doc. of steps to obtain evidence	Discharge Paperwork Referral SelfCert. 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 list and attach											
Notes												
SelfCert. Check	Does the documentation include more than 3 Months of Certifications? * Yes No * Please be advised that if you are not a self-certifying project and you are not a project during an operating year, no more than 3 be self-certified. Please check with your project administrator to ensure your project has not exceeded its self-certification cap.											
Key	Mo. = Month, Yr. = Year, Inst. = Institution, Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description											

## Coordinated Entry Assessment Part 5B - Disability Verification:

Client Name: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

HMIS #: \_\_\_\_\_

As the head of household:

- Yes, I receive SSI, SSDI benefits or VA disability compensation.
- A copy of my Social Security Administration benefits or VA Disability Compensation award letter is included.
- No, I do not receive SSI, SSDI benefits or VA disability compensation.

**If you are not receiving SSI, SSDI benefits or VA disability compensation, a licensed professional (licensed by the State of Illinois to diagnose and treat the disabling condition) must complete the below documentation.**

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**Dear provider:** We appreciate your assistance verifying the disabling condition of this client, so that we may document their eligibility for a supportive housing placement. The Department of Housing and Urban Development (HUD) specifies that, in order to qualify, a client must be diagnosed with a condition that inhibits their ability to live independently and without support or assistance, and their capacity to sustain gainful employment. If you have any questions about how to complete this document, please contact this worker: Thanks so much for your assistance to secure housing for this client!

Worker Name: \_\_\_\_\_

Worker Email: \_\_\_\_\_

Worker Phone: \_\_\_\_\_

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### THIRD PARTY VERIFICATION OF DISABLING CONDITION

**Name and Credentials of Qualified Professional completing this disability verification form:**

Clinician Name: \_\_\_\_\_

Clinician Title: \_\_\_\_\_

Clinician Address: \_\_\_\_\_

Clinician's License #: \_\_\_\_\_

#### DISABILITY DETERMINATION

To qualify for permanent supportive housing a disabling condition must be determined, verified and documented.

- Individual has a disability, as defined in 42 USC 423, which means:
- Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months

**SELECT THE APPROPRIATE CATEGORY BELOW AND CHECK THE APPROPRIATE SUPPORTING BOX(ES):**

Physical, Mental or Emotional Disability 583.5/42usc 11360(9)

A person shall be considered to have a physical, mental or emotional impairment, including an impairment caused by alcohol or drug abuse, if the individual has a disability that:

Is expected to be long-continuing or of indefinite duration;

**AND**

Substantially impedes the individual’s ability to live independently;

**AND**

Is of such a nature that the ability to live independently could be improved by more suitable housing conditions;

AIDS/HIV 583.5/42usc 11360(9)

A person will also be considered to have a disability if he or she has:

acquired immunodeficiency syndrome (AIDS)

**OR**

any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Developmental Disability   
 578.3

A person will be considered to have a developmental disability if the individual has a **severe, chronic disability that:**

Is attributable to a mental or physical impairment or combination of impairments; **AND**

Is manifested before the individual attains age 22; **AND**

Is likely to continue indefinitely; **AND**

Results in substantial functional limitations in **three or more** of the following areas of major life activity:

Self-care

Receptive and expressive language

Learning

Mobility

Self-direction

Capacity for independent living

Economic self-sufficiency

**AND**

Reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

**DIAGNOSIS**

**Disability (with diagnostic code):** \_\_\_\_\_  
 \_\_\_\_\_

I, \_\_\_\_\_, have interviewed and observed this participant and have diagnosed the participant with the disabling condition listed. I have also determined the participant’s condition has been present since \_\_\_\_\_ and limits the participant’s ability to work and/or perform one or more of the following activities of daily living for the following reasons:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature of Qualified Professional

\_\_\_\_\_  
 Date

## Coordinated Entry Assessment Part 5C - Veteran Status Verification:

The information gathered in this form can be used to help expedite housing matching based on the client's vulnerability and needs, and program eligibility. SubCook Continuum of Care provides housing for all veterans, regardless of discharge status, provided they meet other eligibility requirements for the particular programs.

Client Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ HMIS #: \_\_\_\_\_

Branch: \_\_\_\_\_ Dates: \_\_\_\_\_ Discharge Status: \_\_\_\_\_

Are you currently involved with the VA?  Yes  No  
If no, would you like assistance in connecting with VA services?  Yes  No

I give permission for this agency to communicate with the VA about my eligibility for housing and services:  
 Yes  No (We can work to house you even if you don't want us to work with the VA.)

\_\_\_\_\_  
Signature Date

**\*Please submit a copy of the DD214 ASAP.**

## Coordinated Entry Assessment Part 5D - Income Verification:

The information gathered in this form is used to assist in prioritizing housing matching based on the client's available resources. We do not REQUIRE income in order to be housed, but most programs require that clients contribute a portion of whatever income they have toward their rent.

\_\_\_ The client has income from this source(s): \_\_\_\_\_  
(include amounts) \_\_\_\_\_

**\*Please submit a copy of the client's check stubs, award letter, or other income verification.**

(If the client receives income from the street economy or "under the table," problem-solve with the CE Lead team about how to verify this.)

\_\_\_ The client has NO income at this time.

## Coordinated Entry Assessment Part 5E - Identity Verification:

ID is not required for admission into housing, but not having it makes things harder. The following documentation will need to be secured:

- Government-issued photo ID
- Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If not available, why? \_\_\_\_\_

**\*\*Please note: Identification and Social Security Numbers will eventually be needed for all household members. For each adult, current, government issued photo ID is needed. For all household members under the age of 18, Birth Certificates and Social Security Numbers are needed.**

Is assistance needed in obtaining this documentation?  Yes  No