

Application for Heading Home's PSH Programs

I am interested in: congregate housing scattered site housing (check one or both)

Name?_____	Are you at least 18 years old?_____
Some of our programs are gender specific. What is your gender?_____	What is the best way to reach you?_____
Who referred you?_____	

Where are you staying now?_____	How long have you been there?_____
I have lived in (check all that apply) <input type="checkbox"/> Cambridge <input type="checkbox"/> Somerville <input type="checkbox"/> Medford <input type="checkbox"/> Malden <input type="checkbox"/> Everett <input type="checkbox"/> Boston	

Some of our programs are designed to specifically serve people who have disabilities. Do you have a disability?_____ . If so, what?_____
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Do you have income?_____ How much money do you earn or receive each month?_____
Where does your income come from? <input type="checkbox"/> Work <input type="checkbox"/> EAEDC <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Other_____
How much school have you completed?_____

Do you have a history of substance abuse?_____ If yes, are you in recovery?_____
How long have you been in recovery?_____ What is your drug of choice?_____
Do you have any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, are you seeing a therapist?_____
What is your diagnosis?_____

Are you on the Cambridge Housing Authority's SRO list?_____

Are there other things you think we should know?_____

Please return this completed application and Homeless Verification form by mail to:
Heading Home Inc./P.O. Box 390516/Cambridge, MA 02139/attn: Joanna Bowen
or by fax to 617-864-2541 (attn: Joanna Bowen).

Verification of Homelessness

To be eligible for McKinney-Vento (SHP) grant-funded services, a person must meet HUD's definition of "homeless." A person meets HUD's definition if their living situation fits one of the descriptions in the first section of this form.

I hereby verify that the following individual _____ is currently homeless and:

€ Currently staying at an **emergency shelter** or residence that is part of an established shelter system.

Name of Shelter: _____ Date Entered Shelter: _____

(Shelter staff should complete & sign this form, or a letter from the shelter where the client currently resides must be attached.)

€ Currently staying in a **Transitional Housing (TH) or Permanent Supported Housing (PSH) program**, and was homeless in shelter, TH, or in a place not meant for human habitation immediately prior to entering that program.

Name of TH/PSH Program: _____ Date of Entry: _____

Prior Homeless Situation: _____
(Staff from the TH/PSH where the client lives should complete & sign this form, or a letter from that TH/PSH program should be attached. Also attached should be documentation verifying the client's homelessness prior to entering that TH or PSH program.)

€ Sleeping in a **place not meant for human habitation** (e.g., car, park, sidewalk, ATM, abandoned building, etc.) Location: _____

(Outreach staff must complete & sign this form, or a letter from outreach staff verifying the client's homelessness should be attached.)

€ Being **evicted from housing** within one week. (Attach a statement signed by owner/landlord of the property where the client lives indicating that s/he will be evicted within 5 business days.)

€ Homeless due to having fled **domestic violence**. (Attach a statement signed by staff of the DV program.)

€ Being **discharged** from a jail or hospital or residential treatment program with **length of stay less than 30 days**, and was homeless (as defined above) immediately prior to that stay. (Attach the usual documentation of prior homelessness.)

Hospital/Facility name: _____ Date of Entry: _____

Homeless circumstances immediately prior to facility entry: _____

€ Being **discharged** from jail or hospital or inpatient program with **length of stay at least 30 days**, and lacks any housing options despite the best efforts of discharge planning staff.

Hospital/Facility name: _____ Date of Entry: _____

(Attach a statement signed by staff of the discharging institution describing their inability to place the client.)

The named individual should be deemed **chronically homeless** because (all three conditions must be met):

€ S/he is an **unaccompanied Individual**.

€ S/he has a **disabling condition**: "diagnosable substance abuse disorder, serious mental illness, developmental disability and/or chronic physical illness or disability that limits his/her ability to work or perform one or more activities of daily living."

Nature of disability: _____ Evidence/Verification of disability: _____

€ S/he is **currently living on the street or in shelter**, and has been **homeless on the street or in shelter** for at least **one continuous year** or **episodically at least 4 times in the last 3 years**, as described in an **accompanying statement dated and signed by staff and/or the client** giving the dates & locations of the qualifying homelessness.

I understand that false statements or information are punishable under federal law.

Signature of Authorized Program Staff Printed Name and title Date

***Note**: Verifying chronic homelessness for the purpose of **qualifying for targeted resources** is more rigorous than verifying chronic homelessness for **statistical purposes**, and requires **documentation** of the disabling condition and **documentation** of the qualifying periods of homelessness by **appropriate sources** (e.g., residence or outreach staff).

Return form once completed to Po Box 390516, Cambridge MA 02139 or fax it to us at 617-864-2541. Questions about your placement on the list can be directed to Joanna Bowen at 617-864-8140.