Step #1	**Continuum of Care Program Approval Checklist**	Clear All Fields

This checklist is done initially only. If lapse in approval/assistance, this must be done again.

Applicant Name:

Subrecipient/Case Manager:

Date:	**HMIS ID#**	
Documents (Provide copies of originals)	**Included**	**N/A**
Coordinated Entry Placement Cover Sheet (copy of completed form received from RICH)		
RI CoC Authorization to Share Information-HMIS Form		
Intake Certification form		
SS # Verification for all members		
Birth Date Verification for all members		
Photo ID for all adult members		
Authorization of Release of Information and Consent		
Chronic Homelessness/Disability Status Certification		
Chronic Homelessness Verification		
Disability Verification		
Federal Privacy Act Notice		
Due Process Acknowledgement		
Other		

Send all documents to RIHousing for approval. Once you receive approval, unit search can begin.

Rhode Island Continuum of Care Authorization to Share Information

The RI Continuum of Care (RI CoC) is comprised of a network of government agencies and non-profit organizations that provide shelter, housing, and other services to individuals and families who are homeless. In order to provide you with the best services possible, it is important that all of the agencies working with you are able to share information in order to plan and coordinate the services that you need. Only authorized staff that perform case management and/or administrative functions, may exchange information about you in written form (on paper) or verbally (through conversations or telephone calls) or electronically (through a shared database). We must have your written permission to share this information. Your signature on this authorization allows homeless service agencies to share your information in order to give you the best services possible. A list of these agencies is available upon request.

I authorize the RI CoC to share the following information about me with member agencies. **All staff members accessing information are trained in confidentiality procedures. All RI CoC network members have signed agreements to treat personal information confidentially.**

The following information A) is available **only to authorized staff** who need to access the shared database in order to identify clients in their projects as well as to case managers and administrators:

A) Personal identifying information, such as my name, date of birth, and social security number.

The following information B) can be shared **only among authorized staff** that perform case management and/or administrative functions:

B) Income and assets, public benefits, health insurance, housing and employment history, educational background, incarceration history, probation status, behavioral health information, mental health treatment history, physical health information, and past use of homeless services and contacts with network members.

Because the network receives funding from the federal government, we must collect the following information C), which will be stored in a database maintained by Bowman Systems Inc. Aggregate information will be included in reports required by the U.S. Department of Housing and Urban Development but **neither you nor your family members will be individually identified in any of these reports**.:

C) Name; birth date, social security number; gender; ethnicity and race; veteran status, disability status, and prior living situation.

I understand that signing this form does not guarantee that I will receive assistance. Refusing to sign this form will not disqualify me from receiving basic services although some programs will have additional eligibility and information sharing requirements that I will need to meet. I understand that I may withdraw this consent at any time by submitting a written request to the program named below. The withdrawal will become effective on the date signed and does not apply to information that has already been disclosed.

This authorization is valid until I withdraw it in writing.

Client name (print): _____ Signature: _____

Witness name (print): _____ Signature: _____

Program/Agency (print): _____ Date: _____

CONTINUUM OF CARE APPLICANT CERTIFICATION FORM

Applicant Name:_____ Application Date: _____

Address: _____

Telephone: _____Email: _____

Emergency Contact Name: _____ Relation: _____

Address: _____

Telephone: _____

CURRENT/PREVIOUS STATUS:

Have you or any member of your household recently been involved in Domestic Violence? □ Yes □ No

Are you a Veteran? □ Yes □ No If yes, do you receive veteran's benefits? □ Yes □ No

Have you previously participated in the Continuum of Care program? □ Yes □ No

HOUSEHOLD COMPOSITION: List all persons living in your unit.

*RELATIONSHIP CATEGORIES: H=HEAD OF HOUSEHOLD; S=SPOUSE (married); K=CO-HEAD (not married); Y=YOUTH UNDER 18; A=OTHER ADULT; E=FULL TIME STUDENT OVER 18; F=FOSTER CHILD/ADULT; L=LIVE-IN AID

*RACE CATEGORIES: 1=WHITE 2=BLACK 3=AMERICAN INDIAN 4=ASIAN/PACIFIC ISLANDER

	Household Member First & Last Name	Social Security Number	Date of Birth (Month/Day/Year)	Sex (Male or Female)	Ethnicity (Hispanic or Non- Hispanic)	Race*	Relation to Head of Household*	Disabled (Yes or No)
1.								
2.								
3.								
4.								
5.								
6.								
7.								

HEAD OF HOUSEHOLD CERTIFICATION OF ACCURACY

I HEREBY CERTIFY THAT THE ABOVE INFORMATION ON HOUSEHOLD COMPOSITION IS COMPLETE, TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature of Head of Household Date

RI Continuum of Care Authorization for Release of Information and Consent

Subrecipient Name: _____

Purpose: In signing this consent form, you are authorizing the Subrecipient, Rhode Island Housing (RIH) and/or United States Department of Housing and Urban Development (HUD) to get information directly from third party sources to verify the personal identity, employment, income and assets, medical and child care allowances, expenses, cost of services, family composition and related information for every household member. In addition, other documentation may be obtained that is pertinent to my eligibility for and continued participation in a RIH and or HUD funded program. The Subrecipient, RIH and/or HUD will request information from the sources listed on the form to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. The Subrecipient, RIH and/or HUD may participate in computer matching programs with these sources to verify your eligibility and level of benefits

Uses of Information to be obtained: The Subrecipient, RIH and HUD are required to protect the information obtained in accordance with the Privacy Act of 1974, 5 U.S. C. 552a; 42 C.F.R. Part 2. HUD may disclose information (other than tax return information) for certain routine uses such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to Housing Authorities to determine housing assistance. The Subrecipient and RIH are also required to protect the information obtained in accordance with any applicable State privacy law. The Subrecipient, RIH and HUD employees may be subject to penalties for unauthorized disclosures or improper uses of the information that is obtained based on the consent form. Private owners may not request or receive information authorized by this form.

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

GROUPS OR INDIVIDUALS that may be asked to release the above information include, but are not limited to:

Alimony Providers	Public Housing Agencies	Past and Present Employers	State Unemployment Agencies
Banks/other Financial Institutions	Legal Services Providers	Past, Present & Future Landlords	State Wage Information Agencies
Child Support Providers	Law Enforcement Agencies	Retirement/Pension Systems	Utility Companies
Child Care Providers	Medical Care Providers	Schools and Colleges	Veterans Administration
Courts and Post Offices	Mental Health Providers	Social Security Administration	Welfare Agencies
Credit Providers/ Credit Bureaus	Public/Private Benefit Providers	Social Service Agencies	Service Vendors

CONDITIONS

I/We agree that a photocopy of this authorization may be used for the purposes stated above. I/We understand I/we have a right to review this file and correct any information that is incorrect. I/We understand that previous or current information regarding me/us may be needed. Verifications and inquiries that may be requested include but are not limited to are listed above. I/We understand that this authorization cannot be used to obtain any information about me/us that is not pertinent to my eligibility for and continued participation in a RIH and/or HUD funded program. The original of this authorization is on file and **will expire 15 months** after the date signed.

CONSENT

I/We authorize and direct any Federal, State or local agency, organization, business or individual to release to the above listed Subrecipient, RIH and/or HUD any information or materials needed to complete and verify my application for participation, and/or maintain my continued housing assistance. I understand and agree that this authorization or the information obtained with its use may be given to and used by Subrecipient, RIH, and/or HUD in administering and enforcing program rules and policies. The undersigned hereby authorize all persons or companies in the categories listed below to release without liability, information regarding personal identity, employment, income and assets, medical and child care allowances, expenses, cost of services, family composition and related information provided to:

Signatures:

_____ _____
Head of Household **Date** **Other Family Member over 18** **Date**

_____ _____
Spouse/ Co-Head **Date** **Other Family Member over 18** **Date**

_____ _____
Other Family Member over 18 **Date** **Other Family Member over 18** **Date**

WARNING:
It is unlawful to provide false information to the government when applying for federal public benefit programs per Section 1001 of Title 18 of the United States Code

Continuum of Care
Chronic Homelessness and Disability Status Certification

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 and Long-Term Homelessness

1. Is the HOH currently homeless, staying on the streets or in a shelter?
   ☐ Yes (go to question 3) ☐ No ask the next question)

2. Has the HOH been residing in an institutional care facility for fewer than 90 days?
   ☐ Yes (go to question 3) ☐ No (***STOP***, household not eligible for this program)

3. Has the HOH been continuously homeless on the streets or in shelters for 1 year or longer?
   ☐ Yes (continue with the timeline on page 3) ☐ No (ask the next question)

4. Has the HOH experienced 4 or more occasions of streets/shelters homelessness totaling 12+ months in the past 3 years?
   ☐ Yes (continue with the timeline on page 3) ☐ No (***STOP***, household not eligible for this program)

Client must currently be in one of these locations to be considered chronically homeless.

Client is currently residing in:

☐ Emergency Shelter
☐ Unsheltered/On the Streets/Place not Meant for Human Habitation
☐ Safe Haven
☐ Hotel/Motel Paid by the Govt or Charity
☐ Institutional Care Facility (Where they have been for fewer than 90 days)

Is client fleeing or attempting to flee domestic violence (Check One)? ☐YES ☐NO

Homeless Status
(Documentation must be obtained to verify homeless status. Review page 4 for acceptable documentation)

☐Literally Homeless (includes <90 days institution)	☐Imminent Risk of Homelessness	☐Fleeing Domestic Violence

Chronic/Disability Status

Is this applicant chronically homeless? (Review Homeless History) ☐ YES ☐NO
Is this applicant being qualified for permanent supportive housing? ☐YES ☐ NO
If yes to any, complete Part 2. Disability Status and a Disability Verification must be obtained

Start Date:	**End Date:**
Location Name/Address:	
Current Housing Status Notes:	

Part 2: Disability Status

The term 'homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has one or more of the following:

1. Developmental Disability
2. HIV or AIDS
3. Physical, mental, or emotional impairment that meets all the following criteria:
   a. Is expected to be of long-continuing or indefinite duration, and
   b. Impedes the individual's ability to live independently, and
   c. Is such that the ability to live independently could be improved with more suitable housing

Does the HOH have a disability, as defined above?

☐ Yes ☐ No (***STOP***, household not eligible for this program)

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
☐ HIV/AIDS
☐ Other:

Documentation Attached:

☐ Written verification of the disability from a professional licensed to diagnose and treat the disability documented (E.g. Verification of Disability (Form D));
☐ Written verification from the Social Security Administration;
☐ The receipt of a federal disability check; or
☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Client Certification:

To the best of my knowledge and ability, all the information provided on Part1, 2 and 3 of 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 the below listed agency 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:**

Staff Certification: *To the best of my knowledge and ability, all the information and documentation used in making this eligibility determination is true and complete.*

Staff Name: (Printed)	**Staff Signature:**	**Date:**
Staff Role:	**Agency:**	

Notes:

Part 3: Housing History

	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. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. <90d
Doc. Type *Check One*	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.	☐ HMIS ☐ Obsv. ☐ Discharge Paperwork ☐ Referral ☐ Intake ☐ Self-Cert.
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: Break 4: Break 5: Break 6: 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, Cert. = Certification, Descr. = Description* *Referral = Written referral letter or form, or other certification by a provider in their professional capacity*

Required Documentation (This page is for reference only and does not need to be printed and in the file.)

- *A single third-party encounter in a month is sufficient to consider the household homeless for the entire month unless evidence of a break.*
- *If third-party documentation cannot be obtained, second- or first-party documentation is required and:*
  - *You must thoroughly document attempts to obtain third-party documentation and why third-party documentation was not obtained.*
- *At least 9 months of homelessness must be verified with third-party documentation, except:*
  - *In rare/extreme cases - **for no more than 25% of households served in an operating year** - more than 9 months may be documented by second- or first-party documentation.*
- *Regardless of any other documentation obtained, you must obtain documentation of homelessness for the night before entry into the program.*

STREETS OR OTHER PLACE NOT MEANT FOR HUMAN HABITATION	• **Written Third-Party** (one or more of the following)**:** o HMIS record of homeless street outreach contacts o Homelessness Certification (Form A) o Observation of Living Conditions (Form B) o Certification of Homelessness Based on Professional Judgment (Form C) o Signed letter/form referral from a homeless street outreach provider or referral source **OR** • **Written Second-Party** (*both* of the following)**:** o Certification Based on Intake Conversation (Form F) **AND** o Staff Supplement to the Certification Based on Intake Conversation (Form F) describing attempts to secure third party verification **OR** • **Written First-Party** (*both* of the following)**:** o Client Self-Declaration of Homelessness (Form E) **AND** o Staff Supplement to the Self-Declaration of Homelessness (Form E) describing attempts to secure third party verification
EMERGENCY SHELTER or SAFE HAVEN	• **Written Third-Party** (one or more of the following)**:** o HMIS record of shelter stay o Homelessness Certification (Form A) o Observation of Living Conditions (Form B) o Certification of Homelessness Based on Professional Judgment (Form C) o Signed letter/form referral from an emergency shelter provider **OR** • **Written Second-Party** (*both* of the following)**:** o Certification Based on Intake Conversation (Form F) **AND** o Staff Supplement to the Certification Based on Intake Conversation (Form F) describing attempts to secure third party verification **OR** • **Written First-Party** (*both* of the following)**:** o Client Self-Declaration of Homelessness (Form E) **AND** o Staff Supplement to the Self-Declaration of Homelessness (Form E) describing attempts to secure third party verification
HOSPITAL OR OTHER INSTITUTION If the client's stay was less than 90 days or less and was in shelter or on the streets prior to admission, this is part of the occasion of homelessness. If the client's stay 90 days or more, this is a break	• **Written Third-Party** (one of the following)**:** o Letter or discharge paperwork from hospital or other institution, including admission and discharge dates, or o Oral referral documented by staff including admission and discharge dates ***AND*, to document homelessness, at least one of the types of documentation required for streets or shelter homelessness for the client's housing status immediately prior to the stay in the institution: OR** • **Written First-Party** (*both* of the following)**:** o Client Self-Declaration of Homelessness (Form E) **AND** o Staff Supplement to the Self-Declaration of Homelessness (Form E) describing attempts to secure third party verification

Federal Privacy Act Notice

PURPOSE: Family income and other information is being collected by the Department of Housing and Urban Development (HUD) to determine an applicant's eligibility, the recommended unit size, and the amount the family must pay toward rent and utilities.

USE: HUD uses family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest; and to verify the accuracy of the information furnished. HUD or a public housing agency/Indian housing agency may conduct a computer match to verify the information you provided. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law.

PENALTY: You must provide all of the information requested by the public housing agency/Indian housing agency, including all Social Security numbers you, and all other household members six (6) years and older, have and use. Giving the Social Security numbers of all household members six (6) years of age and older is mandatory, and not providing the Social Security numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

AUTHORITY FOR INFORMATION COLLECTION: The following laws authorize the collection of this information by HUD or the public housing agency/Indian housing agency: the U.S. Housing Act of 1937 (42 U.S.C., 1437 et. Seq.), Title VI of the Civil Rights Act of 1964, and Title VIII of the Civil Rights Act of 1968. The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and residents to submit the Social Security numbers of all household members at least six (6) years old.

I read, or had explained to me, the Privacy Act Notice on _____.
Date

_____ _____
Signature of Applicant/Participant Social Security Number

Continuum of Care
Due Process Acknowledgement

This is to inform all applicants and participants in the Continuum of Care Program of their due process rights in the event of an adverse action by the program such as termination. All participants have the right to appeal a termination decision that results in the loss of their rent subsidy and other services. The following are the steps to terminate a participant from the CoC Program and the participant's due process steps to appeal the termination decision:

In the event of a decision to deny/terminate an applicant/participant from the CoC Program, the case manager will verbally inform the participant and attempt to develop a written contract delineating the responsibilities of all concerned parties to avoid a termination action.

If the case manager and the sub-recipient determine that the contract is not being followed by the participant, the sub-recipient will inform the Rhode Island Housing (RIH) of their recommendation to terminate the participant from the program.

1. If RIH agrees with the housing provider's recommendation to deny/terminate, a written letter will be sent to the applicant/participant by the sub-recipient with the date of the denial or termination and rental subsidy will end. The letter will have instructions for the applicant/participant to appeal this decision.

2. The applicant/participant will have thirty (30) calendar days after receipt of the termination letter to appeal the decision by returning a letter requesting an appeal to the sub-recipient.

3. After the sub-recipient receives the letter to appeal from the applicant/ participant, the sub-recipient will conduct an appeal hearing within ten (10) business days that the applicant/participant must attend in order to present their case.

4. The sub-recipient appeal panel must render a decision and inform the/ participant of their decision in writing within ten (10) business days following the appeal hearing.

5. If the participant disagrees with the sub-recipient appeal panel's decision, the participant may request a second level of appeal to RIH within ten (10) business days after receipt of the sub-recipient appeal panel's letter of the decision.

6. The applicant/participant will be provided a letter and envelope addressed to RIH to request the appeal. RIH will conduct the appeal hearing within ten (10) business days of receipt of the appeal request. The participant must attend the hearing to present their case.

7. The RIH appeal panel will inform the applicant/participant and sub-recipient in writing within ten (10) business days following the appeal hearing of their decision.

8. RIH may decide to uphold the termination, cancel the termination, or provide conditions the participant must meet to remain in the program and designate a follow-up progress report. If progress is not demonstrated by the applicant/participant to meet the RIH appeal panel conditions, the decision to deny/terminate will be made. Likewise, if the applicant/participant demonstrates satisfactory progress towards meeting the conditions stated by RIH to remain in the program, the denial/termination will be rescinded. <u>The decision by the RIH appeal panel is final and cannot be appealed further.</u>

Composition of the Appeal Panel

The sub-recipient appeals panel shall consist of members of other housing provider's that are not party to the termination decision.

The RI CoC appeals panel shall consist of members of housing provider's that are not party to the termination decision and the Manager of the RI CoC Program or his/her designee.

What are the factors leading to the decision to terminate a participant from the CoC Program?

The sub-recipient will only recommend termination as a last resort. Usually, participants are terminated for multiple reasons which may include failure to pay rent, violating key lease or occupancy agreement conditions, violence, using and selling illegal drugs, and committing felony offenses. Compliance to the agreed upon service agreement to obtain or seek treatment, income, and other services is also a factor.

If the participant makes substantial progress in resolving the reasons for program termination, the sub-recipient may rescind the termination at any point in the process.

I acknowledge the above due process and termination procedures, have received a copy of this form, and understand or have had them read and/or explained to me.

_____

Applicant/participant signature Date

_____

Sub-recipient representative signature Date