

Form A: Third-Party Verification - Service Providers

Directions: Please fill out all sections **completely** and be sure handwriting is legible.

Who can use this form: Service Providers encountering someone experiencing homeless while working in their professional capacity. Service providers include shelter staff, outreach, homeless or housing services staff, law enforcement, medical practitioners, school workers, mental health practitioners.

If you encountered the person while they were experiencing homelessness, please complete this form indicating what months you encountered them. If you encountered the person in a setting other than where they sleep (such as doctor's office or service agency), you must explain why you believe the person is/was homeless without having seen their living conditions.

Participant name: _____

Where did/does the person sleep? (general description, city, state) <i>Ex: camp in woods Sanford</i>	Did you see where the person sleeps with your own eyes?	What Month and Year did you encounter the person experiencing homelessness?	Describe the observed conditions of where the person sleeps. If you encountered person in a location other than where they sleep, why do you believe they are homeless?
	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, must provide further description)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, must give reason for statement)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, must give reason for statement)		

Additional comments: _____

To the best of my knowledge in my professional judgement, I certify that the above statements are true and correct.

Printed Name of Worker Certifying to the homelessness above

Address

Title/Role

Phone Number

Organization

Date

Signature (if worker is completing this form directly)

Navigator completed form on behalf of worker after discussing their encounters with the person experiencing homelessness.

Navigator name

Navigator Signature

Form B: Third-Party Verification - Institutional Care Facility

Directions: Please fill out all sections **completely** and be sure handwriting is legible.

Who can use this form: Staff at Emergency Shelters, Mental Health Facilities, Hospitals, treatment centers, or any facility where person stayed overnight.

I certify that _____ stayed at _____
 (Person's Name) (Facility/Program Name)

	When did they enter and exit your facility? List all stays you have on record within the past 3 years		Based on your intake and to the best of your knowledge, did the person enter your facility directly from the streets or an emergency shelter?
	Entry Date	Discharge Date	
1			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
6			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

What is your facility/program classified as:

- Emergency Shelter
- Safe Haven
- Mental Health Institution
- Medical Institution
- Correctional Facility
- Addiction Treatment Program
- Rehabilitation Center
- Transitional Housing
- Other: _____

 Printed Name of Worker Completing this form

 Organization

 Signature of Worker or Provider Completing this form

 Address

 Title/Role

 Phone Number

 Date

Form C: Homeless Self-Certification

Directions: Please fill out all sections **completely** and be sure handwriting is legible.

Who can use this form: The participant can certify their own homelessness for up to 3 months, if 3rd party homeless verification is unavailable. This should only be used as a last resort after 3rd party verification is not available, possibly due to no response from 3rd party or because no one witnessed the homelessness.

Participant Name: _____

Complete Time Frame and Descriptions:

Time Period (Month/Year)	City/State of Location	Give specifics on the living situation for the months 3 rd party verification is unavailable	Steps taken to obtain 3 rd party verification
			<input type="checkbox"/> Attempts made, no response <input type="checkbox"/> 3 rd party verif. doesn't exist
			<input type="checkbox"/> Attempts made, no response <input type="checkbox"/> 3 rd party verif. doesn't exist
			<input type="checkbox"/> Attempts made, no response <input type="checkbox"/> 3 rd party verif. doesn't exist

Person's Certification

I, _____, certify that I have lived in an emergency shelter or place not meant for human habitation as noted above. I certify that the dates, locations, and descriptions noted above are true.

Person's Signature: _____ Date _____

Navigator's Certification

As the above person's Housing Navigator, I certify that I have attempted to obtain 3rd party verification of their homelessness for the dates above, but it was not available. I certify that to the best of my knowledge and in my professional judgement that the dates, locations, and descriptions noted above are true and correct.

Printed Name of Navigator completing this form

Address

Signature of Navigator

Phone Number

Organization

Date

Form D: Third-Party Verification – Community Members

Who can use this form: A Navigator can accept 3rd party verification, verbal or written, from someone in the community who has **physically observed where the person is sleeping/living**. Navigators must use their professional judgement to determine if the source is reliable. Community members include store owners/managers, church staff, neighborhood residents, postal service workers, etc.

Directions: If the community member is unable to provide written verification directly on this form, Navigator may document their conversation with the community member using this form. The community member must indicate which specific months they physically observed where the person has been sleeping/living.

Acceptable community verifications: Store owner sees person sleeping on their property, neighborhood resident sees person in and out of their camp, church staff allowing person to sleep on the property, etc.

Unacceptable community verifications: Person self-reports to community member they are homeless, community member encounters person in a setting other than where they sleep, such as panhandling sites or at church.

Participant name: _____

Where did/does the person sleep? (general description, city, state) <i>Ex: camp in woods, Orlando, FL</i>	Did you see where the person sleeps with your own eyes?	What Month and Year did you see where the person sleeps?	Describe the observed conditions of where the person sleeps
	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, stop here. We are unable to proceed)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, stop here. We are unable to proceed)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, stop here. We are unable to proceed)		

Community Member’s Certification:

How does Community Member know the participant: _____

Community Member printed name: _____

Community Member Signature: _____ Date: _____
(If Community member is completing this form directly)

Navigator’s Certification

Navigator printed Name

Address

Navigator Signature

Phone

Organization

Date