Missouri Department of Mental Health
Shelter Plus Care Program
Eligibility Packet

GENERAL INFORMATION

• For help with this form or eligibility information, contact the DMH Housing Unit at housing@dmh.mo.gov or 573-522-2120.
• FAX completed eligibility packet to the DMH Housing Unit at 573-526-7797.
• Download this form as a PDF file at: http://dmh.mo.gov/housing/housingunit/shelterpluscare.html#applyingforspcassistance.

DETAILED PROGRAM INFORMATION

• For an overview of DMH’s Shelter Plus Care programs, visit: http://dmh.mo.gov/housing/housingunit/shelterpluscare.html.
• For complete information, see the DMH Housing Manual at: http://dmh.mo.gov/housing/housingunit/shelterpluscare.html#dmhhousingmanual.

REQUIRED DOCUMENTS

All adults in households seeking assistance must have the following in order to receive assistance: a state-issued picture ID; proof of Social Security number; and proof of income, if any. Minors must have a copy of their birth certificate and proof of Social Security number, if applicable. If any of these items are missing, you should begin to work on obtaining them immediately. You don’t need to include them in this eligibility packet, but you must have them available at your initial briefing at a local processing center. The briefing is your required first step in Shelter Plus Care before looking for a rental unit.

An incomplete eligibility packet slows review time and delays housing assistance.
For the fastest possible determination of eligibility:

• Be sure you have the most current version of the Eligibility Packet before you begin. You can check for the latest version by visiting http://dmh.mo.gov/housing/housingunit/shelterpluscare.html#applyingforspcassistance.
• Read the instructions found throughout the packet to be sure you are filling it out correctly. If you have a question or need help, it’s better to contact DMH Housing first than to submit a packet you’re not sure is complete and correct.
• Include documentation of the household’s homelessness. This is required. No household can be found eligible for assistance without documentation of homelessness. See Attachment B, Verification of Homelessness Guide (page 10), for more information about documenting homelessness.
• Make sure this form is legible and will remain so after you fax it to us. Use only dark-colored ink.
• Save time and paper—Don’t fax us these instructions.
Shelter Plus Care Eligibility Packet

SECTION 1. HEAD OF HOUSEHOLD (HOH) INFORMATION

Head of Household Name: _____________________________________________________________________________________

Social Security Number: _______ - _______ - _______

Date of Birth: _________ / _________ / _________

Military Veteran: □ Yes  □ No

Gender: □ female  □ male  □ does not identify
         □ transgender, male to female
         □ transgender, female to male

Primary Race:    Ethnicity:
□ American Indian/Alaska Native    □ Hispanic
□ Asian                          □ non-Hispanic
□ Black/African-American         □
□ Native Hawaiian/Other Pacific Islander □
□ White

Secondary Race (if any):
□ American Indian/Alaska Native  □ Asian
□ Black/African-American        □
□ Native Hawaiian/Other Pacific Islander □
□ White

Location – CoC Code
□ MO-501 (St. Louis City) □ MO-600 (Springfield)
□ MO-500 (St. Louis County) □ MO-602 (Joplin)
□ MO-606 (Balance of State) □ MO-603 (St. Joseph)
□ MO-604 (Kansas City)

County:_________________________________

Last Permanent Address/Location:
What is the zip code of your last permanent address (a household paying rent or a mortgage where you last lived for at least 90 days)?

Zip Code __________________________________________________________

Do you have health insurance? Check all that apply.
□ Medicare    □ Medicaid (aka MO HealthNet)
□ employer-provided health insurance
□ health insurance obtained through COBRA
□ VA Medical Services    □ private pay insurance
□ no insurance □ Indian Health Services Program
□ State Children’s Health Insurance Program (SCHIP)
............................................................................................................

Where did you spend the night before you filled out the Shelter Plus Care Eligibility Packet?

[The answer below must match the documentation provided with Attachment B, Verification of Homelessness.]

□ emergency shelter (includes a domestic violence shelter and a motel or hotel room paid for by an emergency shelter voucher)
□ a place not meant for human habitation (car, park, etc.)
□ interim housing (transitional housing)
□ Safe Haven
□ jail or prison
□ substance abuse treatment facility or detox center
□ hospital or other residential non-psychiatric medical facility
□ psychiatric hospital or similar facility
□ long-term care facility or nursing home
□ Foster care home or foster care group home

How long did you stay?
□ one night or less  □ two to six nights
□ one week or more, but less than one month
□ one month or more but less than 90 days
□ 90 days or more but less than one year
□ one year or longer

Approximate date homelessness started:___/____/_______

Number of times client has been on the street or Emergency Shelter in the past three years?
□ Never □ 1 □ 2 □ 3 □ 4+

Total number of months homeless on the street or in emergency shelter in past 3 years?

__________
Head of Household Name: _____________________________________________________________________________________

Do you have a substance use disorder?

☐ yes, alcohol use  ☐ yes, drug use
☐ yes, both alcohol and drug use  ☐ No

If yes, is the substance use disorder a disabling condition?  ☐ Yes  ☐ No

[If you stated that your disability is a substance use disorder or a dual diagnosis that includes a substance use disorder on Attachment A of the Shelter Plus Care Eligibility Packet, then you must answer “yes” to the above question.]

Are you receiving services or treatment for the substance use disorder?

☐ Yes  ☐ No

Do you have a chronic health condition***?

(***See a list of some medical conditions that are considered chronic health conditions at the end of this page.)

☐ Yes  ☐ No  ☐ don’t know

If yes, please specify what the condition is:

______________________________________________

If yes, is the chronic health condition a disabling condition?

☐ Yes  ☐ No

If yes, are you receiving services or treatment for the chronic health condition?

☐ Yes  ☐ No

Do you have a developmental disability?**

(**See definition of “developmental disability” at the end of this page.)

☐ Yes  ☐ No

If yes, is the developmental disability a disabling condition?

☐ Yes  ☐ No

[If you stated that your disability is a developmental disability on Attachment A of the Shelter Plus Care Eligibility Packet, then you must answer “yes” to the above question.]

If yes, are you receiving services or treatment for the developmental disability?

☐ Yes  ☐ No

Do you have a diagnosis of HIV or AIDS?

☐ Yes  ☐ No

If yes, is this a disabling condition?

☐ Yes  ☐ No

[If you stated that your disability is a diagnosis of HIV or AIDS on Attachment A of the Shelter Plus Care Eligibility Packet, then you must answer “yes” to the above question.]

If yes, are you receiving services or treatment for HIV or AIDS?

☐ Yes  ☐ No

Do you have a mental illness?

☐ Yes  ☐ No

If yes, is the mental illness a disabling condition?  (See definition of “disabling condition” at the end of this page.)

☐ Yes  ☐ No

[If you stated that your disability is a mental illness or a dual diagnosis that includes mental illness on Attachment A of the Shelter Plus Care Eligibility Packet, then you must answer “yes” to the above question.]

Are you receiving services or treatment for the mental illness?

☐ Yes  ☐ No

Do you have a physical disability?

☐ Yes  ☐ No  ☐ don’t know

If yes, please specify what the disability is:

______________________________________________

If yes, is the physical disability a disabling condition?

☐ Yes  ☐ No

Are you receiving services or treatment for the physical disability?

☐ Yes  ☐ No

Have you ever been a victim of domestic violence?

☐ Yes  ☐ No  ☐ refused to answer

If yes, how long in the past did this occur?

☐ Within past three months  ☐ 3-6 months ago (excluding six months exactly)
☐ 6-12 months ago (excluding one year exactly)  ☐ One year ago or more
☐ refused to answer

Are you currently fleeing domestic violence?

☐ Yes  ☐ No  ☐ don’t know  ☐ refused to answer

* “Disabling condition” means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person’s ability to live independently.

** “Developmental disability” includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** Chronic health conditions include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome (PTSD), dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.
## SECTION 2. OTHER HOUSEHOLD MEMBER INFORMATION

Fill out one Section 2 per other household member. Omit this section if there are no other household members.

**Head of Household Name:**

**Other Household Member Name:**

<table>
<thead>
<tr>
<th>Social Security Number:</th>
<th>-</th>
<th>-</th>
<th>Date of Birth:</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

**Military Veteran:**

- [ ] Yes
- [ ] No

**Gender:**

- [ ] female
- [ ] male
- [ ] does not identify
- [ ] transgender, male to female
- [ ] transgender, female to male

**Primary Race:**

- [ ] American Indian/Alaska Native
- [ ] Asian
- [ ] Black/African-American
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] White

**Ethnicity:**

- [ ] Hispanic
- [ ] non-Hispanic

**Secondary Race (if any):**

- [ ] American Indian/Alaska Native
- [ ] Asian
- [ ] Black/African-American
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] White

**What is this household member’s relationship to the HOH?**

- [ ] spouse
- [ ] significant other/partner
- [ ] parent
- [ ] step-parent
- [ ] grandparent
- [ ] aunt
- [ ] uncle
- [ ] step-child
- [ ] brother
- [ ] sister
- [ ] son
- [ ] daughter
- [ ] niece
- [ ] nephew
- [ ] roommate
- [ ] other

**Location – CoC Code**

- [ ] MO-501 (St. Louis City)
- [ ] MO-600 (Springfield)
- [ ] MO-500 (St. Louis County)
- [ ] MO-602 (Joplin)
- [ ] MO-606 (Balance of State)
- [ ] MO-603 (St. Joseph)
- [ ] MO-604 (Kansas City)

**County:**

- __________________________

**Last Permanent Address/Location:**

What is the zip code of your last permanent address (a household paying rent or a mortgage where you last lived for at least 90 days)?

- Zip Code __________________________

**Do you have health insurance? Check all that apply.**

- [ ] Medicare
- [ ] Medicaid (aka MO HealthNet)
- [ ] employer-provided health insurance
- [ ] health insurance obtained through COBRA
- [ ] VA Medical Services
- [ ] private pay insurance
- [ ] no insurance
- [ ] Indian Health Services Program
- [ ] State Children’s Health Insurance Program (SCHIP)

**Did this household member spend the night in the same place as the Head of Household (HOH) the night before the Shelter Plus Care Eligibility Packet was filled out?**

- [ ] Yes
- [ ] No

If the answer above is “no,” please complete the following:

**Where did you spend the night before you filled out the Shelter Plus Care Eligibility Packet?**

- emergency shelter (includes a domestic violence shelter and a motel or hotel room paid for by an emergency shelter voucher)
- a place not meant for human habitation (car, park, etc.)
- interim housing (transitional housing)
- Safe Haven
- jail or prison
- substance abuse treatment facility or detox center
- hospital or other residential non-psychiatric medical facility
- psychiatric hospital or similar facility
- long-term care facility or nursing home
- Foster care home or foster care group home

**How long did you stay?**

- one night or less
- two to six nights
- one week or more, but less than one month
- one month or more but less than 90 days
- 90 days or more but less than one year
- one year or longer

**Approximate date homelessness started:** ___ / ___ / ______

**Number of times client has been on the street or Emergency Shelter in the past three years?**

- [ ] Never
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4+

**Total number of months homeless on the street or in emergency shelter in past 3 years?**

- __________________________

- __________________________
Head of Household Name: _____________________________________________________________________________________

Other Household Member Name:_______________________________________________________________________________

Does this household member have a substance use disorder?
☐ yes, alcohol use ☐ yes, drug use
☐ yes, both alcohol and drug use ☐ No

If yes, is the substance use disorder a disabling condition?
☐ Yes ☐ No

Are you receiving services or treatment for the substance use disorder?
☐ Yes ☐ No

Does this household member have a chronic health condition***?
(***See a list of some medical conditions that are considered chronic health conditions at the end of this page.)
☐ Yes ☐ No ☐ don’t know

If yes, please specify what the condition is:
______________________________________________________________________________

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No

If yes, are you receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Does this household member have a developmental disability**?
(**See definition of “developmental disability” at the end of this page.)
☐ Yes ☐ No

If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No

If yes, are you receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Does this household member have a diagnosis of HIV or AIDS?
☐ Yes ☐ No

If yes, is this a disabling condition?
☐ Yes ☐ No

If yes, are you receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Does this household member have a mental illness?
☐ Yes ☐ No

If yes, is the mental illness a disabling condition?
(“See definition of “disabling condition” at the end of this page.)
☐ Yes ☐ No

Are you receiving services or treatment for the mental illness?
☐ Yes ☐ No

Does this household member have a physical disability?
☐ Yes ☐ No ☐ don’t know

If yes, please specify what the disability is:
______________________________________________________________________________

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No

Are you receiving services or treatment for the physical disability?
☐ Yes ☐ No

Has this household member ever been a victim of domestic violence?
☐ Yes ☐ No ☐ refused to answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago (excluding six months exactly)
☐ 6-12 months ago (excluding one year exactly)
☐ One year ago or more
☐ refused to answer

Are they currently fleeing domestic violence?
☐ Yes ☐ No ☐ don’t know ☐ refused to answer

* “Disabling condition” means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person’s ability to live independently.

** “Developmental disability” includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** Chronic health conditions include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome (PTSD), dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.
SECTION 3. INCOME

CASH INCOME

Do you or anyone who will live with you receive cash income from any source currently? □ Yes □ No

If yes, please check the boxes next to all sources of CASH income in the list below received by all household members (do not include food stamps); indicate which household member actually receives the income; and state the amount received per month.

<table>
<thead>
<tr>
<th>Type</th>
<th>Names of Persons Who Have the Cash Income</th>
<th>Amount/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Employment income</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Unemployment Insurance</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Supplemental Security Income (SSI)</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Social Security Disability (SSDI)</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ VA Service-Connected Disability Comp.</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Private disability insurance</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Worker’s Compensation</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ TANF</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Social Security retirement</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ VA Non-Service Disability Pension</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Pension or retirement from a former job</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>(includes military pension)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Child support</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Alimony or other spousal support</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ Other sources of income: specify any other sources of cash income, monthly amount, and who has the income, below:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NON-CASH BENEFITS

Do you or anyone who will live with you receive non-cash benefits or services currently? □ Yes □ No

Please check the boxes next to all sources of NON-CASH benefits and services, and give the name of the household member who has or receives the benefits/services. For food stamps/EBT/SNAP, provide the amount received per month.

<table>
<thead>
<tr>
<th>Type</th>
<th>Names of Persons Who Have the Non-Cash Benefits</th>
<th>Amount/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Food stamps/EBT/SNAP</td>
<td></td>
<td>$ ___________</td>
</tr>
<tr>
<td>☐ WIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ VA Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ TANF childcare services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ TANF transportation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other TANF-funded services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other sources</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION 4. HEAD OF HOUSEHOLD CERTIFICATIONS

Head of Household: please read the statements below and sign to show that you have read the information, understand it, and agree to it.

- I understand that if I am approved to receive assistance from the Department of Mental Health’s Shelter Plus Care program, I agree to comply with all of the rules of the Shelter Plus Care program.
- I understand that I must report all increases and decreases in my income to my local processing center agency within 30 days of the change in income.
- I understand that as a Shelter Plus Care participant I am required to comply with the terms of my lease.
- I certify that all information provided by me is accurate and complete to the best of my knowledge. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

(Print Name of Head of Household, or of Parent, Guardian, or Legal Representative of Head of Household)

(Signature of Head of Household, or of Parent, Guardian, or Legal Representative of Head of Household)

(Date)      (Client Telephone Number)

SECTION 5. REFERRING AGENCY CERTIFICATIONS

Referring Agency Contact person: please read the statements below and sign to show that you have read the information, understand it, and agree to it.

- I understand that by referring this Head of Household to the Shelter Plus Care program, my agency is committing to providing support for the Head of Household necessary for the securing of a rental unit.
- I will ensure that all school-age children in the household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.
- I will attend the initial Shelter Plus Care orientation meeting with the Head of Household at the local processing center agency, once the Head of Household has been approved to receive Shelter Plus Care assistance.
- I will assist the Head of Household in his or her housing search once the Head of Household is approved for Shelter Plus Care assistance.
- I certify that all information provided by me is accurate and complete to the best of my knowledge. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

(Print Name of Referring Agency Contact Person)      (Telephone Number)

(Signature of Referring Agency Contact Person)      (Name of Referring Agency)

(Date)

(Agency Contact Person E-mail Address)

(Print Name of Referring Agency Supervisor/Alternate Contact)
ATTACHMENT A. VERIFICATION OF DISABILITY

Please read: This form may be completed only by a person who can make one of the diagnoses listed on the form below within their scope of professional practice, as defined by the Revised Statutes of Missouri or by a credentialing agency recognized by the State of Missouri. Please indicate your professional licensure by checking a box below:

- Advanced Practice Registered Nurse
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Physician
- Psychiatrist
- Psychologist

The Missouri Dept. of Mental Health’s (DMH) Shelter Plus Care program is a permanent supportive housing program funded by the federal Dept. of Housing and Urban Development (HUD). HUD’s eligibility requirements for Shelter Plus Care specify that the person receiving assistance must be considered disabled. HUD defines a disability as a condition that:

1. is expected to be long-continuing or of indefinite duration;
2. substantially impedes the individual’s ability to live independently; and
3. could be improved by the provision of more suitable housing conditions.

To be considered disabled for purposes of establishing Shelter Plus Care eligibility, the diagnosis must have these characteristics. If you agree that it does, please specify below which diagnosis the individual has, and indicate your assessment of disability status by completing the bottom of the form. Please choose only one diagnosis. If more than one applies to this person, choose the one that most closely fits the characteristics stated above.

The assessed individual, _________________________________________________ (name), has been diagnosed as follows:

- Serious mental illness
- Chronic alcohol use disorder and/or a chronic drug use disorder
- Both a serious mental illness and a chronic alcohol or drug use disorder
- Severe and chronic developmental disability that:
  1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
  2. Manifested before the individual attained the age of 22;
  3. Is likely to continue indefinitely;
  4. Results in substantial functional limitations in three or more of the following areas of major life activity (please check a minimum of three of the following):
     - Self-care
     - Receptive and expressive language
     - Learning
     - Mobility
     - Self-direction
     - Capacity for independent living
     - Economic self-sufficiency; and
  5. 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 of HIV and/or AIDS

I have personally made the diagnosis specified above. The above individual has a disability that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person’s ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

 _____________________________________________  _____________________________________________________
(Print Name of Person Verifying Disability) (Signature of Person Verifying Disability)

______________________________
License Number (required): ______________________________________
(Date)

Missouri Dept. of Mental Health                           SPC Eligibility Packet                          Revised April 2017
ATTACHMENT B. VERIFICATION OF HOMELESSNESS GUIDE

Please document the past 3 years of homelessness. Begin with the current episode and work your way back. Each episode must be documented in letter form. You may have multiple letters from various agencies. No Head of Household can be found eligible for assistance without required documentation of homelessness.

To be considered homeless for the purposes of Shelter Plus Care, you must reside in one of the following situations:

**“Street” Homelessness**: a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; includes places like a car, a park, an abandoned building, a camping ground, sleeping in a tent in the woods, etc.

**Emergency Shelter**: a supervised publicly or privately operated shelter designated to provide temporary living arrangements. This includes emergency shelters, domestic violence shelters, Safe Havens, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

**Transitional Housing**: For transitional housing programs, obtain a letter from the transitional housing program verifying the dates of residence by the Head of Household; and documentation that the Head of Household’s housing immediately prior to the transitional program was an emergency shelter, Safe Haven, or a place not meant for human habitation.

**Institutional Stay**: a person is considered homeless if he or she is exiting an institution where he or she stayed for 90 days or less and lived in an emergency shelter, Safe Haven, or a place not meant for human habitation immediately before entering the institution. An institution includes a medical or psychiatric hospital; an in-patient treatment program; a nursing home, respite bed situation, or other typically congregate setting; and jail or other correctional facilities.

Each Homelessness Verification Letter must have the following elements:

- On agency letterhead or other letterhead of the person verifying the information.
- Signed and dated.
- Have beginning and ending dates of each homeless episode in this format: month, day, year.
- Provide an address or exact location of where the client was residing for each homeless episode.
- For “street” homelessness a case manager or outreach worker must write they have observed the client in that situation.
- For motels paid for by charitable organizations, you will need a letter from the organization stating they paid for motel stay and receipts as well as all other verification requirements listed.

Please see the next page for sample letters of verification.
Street Homelessness Verification

“Date

To Whom It May Concern:

I have observed John Doe sleeping on a bench in ABC Park on several occasions from January 1, 2012, until the present time. Prior to this, I observed John Doe sleeping in an abandoned house at 123 Alphabet Street, Smalltown, MO 54101, from October 11, 2011 until December 31, 2011.

Sincerely,

Case Manager

Case Manager”

Emergency Shelter

“Date

To Whom It May Concern:

John Doe began residing at ABC Shelter on January 1, 2012 and continues to reside with us at this time.

Sincerely,

Shelter Director

Shelter Director”

Transitional/Institutional Housing

“Date

To Whom It May Concern:

John Doe began residing at 123 Transitional Housing on March 1, 2012 and continues to reside with us at this time. Prior to this, John Doe resided at ABC Shelter from January 1, 2012 until February 28, 2012.

Sincerely,

Case Manager

Case Manager”

*For transitional or institutional housing, you must include in your letter that the client was either in an emergency shelter or “street” homeless immediately prior to entry into the transitional program or institution.
ATTACHMENT C. CONSENT FOR DISCLOSURE OF HEAD OF HOUSEHOLD’S PROTECTED HEALTH INFORMATION

I, (full name): ______________________________________________________________________________,

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

hereby authorize the MISSOURI DEPARTMENT OF MENTAL HEALTH (DMH) and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

DMH rent subsidy processing center
Homeless management information data system (HMIS)
U.S. Department of Housing and Urban Development (HUD)
local housing authority
rental property owner or manager

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DMH’s rent subsidy programs Shelter Plus Care and/or Rental Assistance Program, or through a local housing authority.

DMH does not have my permission to disclose the following items:____________________________________________
__________________________________________________________

I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug use, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Missouri Department of Mental Health, Housing Director, 1706 East Elm Street, Jefferson City, MO, 65101.

I understand that this consent remains effective until I am no longer a participant in the DMH rent subsidy program, unless I specify expiration on the following date, or based on the following event or special condition: ______________________

I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DMH cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Would you like a copy of this consent form? Please initial: ( ) YES ( ) NO

Signature of Consumer: __________________________________________  Date: _______ / _______ / ________

Signature of Witness: ____________________________________________  Date: _______ / _______ / ________

Signature of Parent/Guardian/Representative: ______________________  Date: _______ / _______ / ________

Guardian/Representative: please include a description of authority to act on Consumer’s behalf:

_________________________________________________________________________________________________
The Homeless Management Information Systems Network is a group of agencies working together to provide services to homeless and low-income individuals in the State of Missouri. This group includes shelter, housing, food, state, private, and non-profit social service agencies, and faith-based organizations. I give this partner agency permission to share the following information regarding my household. I understand that this information is for the purpose of assessing needs for housing, utility assistance, food, counseling and/or other services.

The information being shared may consist of the following:

- Identifying and/or historical information regarding my household.
- My household income, non-cash benefits, and health insurance information.

I understand that:

- Information I give concerning physical or mental health problems will not be shared with other partner agencies in any way that identifies me or other members of my household.
- The partner agencies have signed agreements to treat my household’s information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS.
- Staff members of the partner agencies who will see my household’s information have signed agreements to maintain confidentiality regarding my household’s information.
- The partner agencies may share non-identifying information about the people they serve with other parties working to end homelessness.
- I have the right to refuse to answer certain questions.
- The sharing of information does not guarantee that services will be provided. Declining to share information does not prohibit the provision of services.
- This authorization will remain in effect for twelve months unless I revoke it in writing.
- If I revoke my authorization, all information about my household entered into the database from that date forward will not be shared with partner agencies.
- A list of the partner agencies within the network may be viewed prior to signing this form.

Agency Name ____________________________________  Project Name ____________________________________

Client Name (please print) ___________________________  Client Signature ___________________________  Date _____________

Agency Personnel Name (please print) ___________________________  Agency Personnel Signature ___________________________  Date _____________