

Homeless Certification Form

This document is used to certify that the below individual or household meets the definition of homeless as detailed in [24 CFR 578.3](#). Households without dependent children must complete one form for each adult within the household. The individual or household must checkmark the criteria that matches their circumstances, include additional relevant information, and sign to indicate their current living situation.

Note: This Homeless Certification is Valid for 30 days from the date that it is signed

Household Information

Applicant Name: _____ HMIS ID #: _____

Household Size: _____ Dependent Children: ☐ Yes ☐ No

Check only one box and complete only that section

Living Situation: place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

- ☐ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus station, airport, or campground.

Description of current living situation:

Organization Name: _____ Phone Number: _____

Staff Name: _____ Title: _____

Program Entry Date: _____ Program Exit Date: _____

The certifying agency must be recognized by the Merced City & County Continuum of Care (CA-520) as an agency that has a program designed to serve persons living on the street or other places not meant for human habitation. Examples may be street outreach workers, day shelters, soup kitchens, Health Care for the Homeless sites, probation and/or parole officers, case managers, etc.

Authorized Agency Representative Signature

Date

Living Situation: Emergency Shelter (ES)

- ☐ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a supervised publicly or privately operated shelter as follows:

ES Program Name: _____ Phone Number: _____

Staff Name: _____ Title: _____

Program Entry Date: _____ Program Exit Date: _____

This Emergency Shelter must appear on the Merced City & County Continuum of Care (CA-520) Housing Inventory Count Report submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Emergency Shelter).

Authorized Agency Representative Signature

Date

Living Situation: Transitional Housing (TH)

- ☐ The person named above is currently living in a transitional housing program for persons who are homeless.

TH Program Name: _____ Phone Number: _____

Staff Name: _____ Title: _____

Program Entry Date: _____ Program Exit Date: _____

Immediately prior to entering transitional housing the person(s) named above was/were residing in:

- ☐ Emergency Shelter ☐ A place unfit for human habitation

This Transitional Housing program must appear on the Merced City & County Continuum of Care (CA-520) Housing Inventory Count Report submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Transitional Housing program).

Authorized Agency Representative Signature

Date

Living Situation: Institutional Setting

- ☐ The person named above is currently residing in an institutional setting. They were homeless prior to entering the institution and they will be homeless upon exiting.

Institution Name: _____

Phone Number: _____

Staff Name: _____

Title: _____

Entry Date: _____

Exit Date: _____

Authorized Agency Representative Signature

Date

Living Situation: Fleeing/ Attempting to Flee DV

- ☐ Individual is fleeing or is attempting to flee domestic violence, where they have no other residence and lack the resources or support networks to obtain other permanent housing. The following verification is attached.

- ☐ **HUD Form 5382 attached**, Self-certification or intake worker certification stating individual is: (i)fleeing; (ii) has no subsequent residence; and (iii) lacks resources; for non-victim service providers, please refer to 24 CFR 578. 103

Authorized Agency Representative Signature

Date

Unable to Verify Homelessness

- ☐ Not able to verify homelessness

Organization Name: _____

Phone Number: _____

Staff Name: _____

Title: _____

If not able to verify homelessness document the attempts made and reason for being unable to verify homelessness.

Authorized Agency Representative Signature

Date