

Chronic Homeless Summary: Please complete this form in its entirety.

In the table below, chart the Head of Household’s (HoH) housing situation for one year or three years, depending on the category by which they are qualified. Attach sufficient documentation for each change in housing situation. Up to 3 months (or one episode) can be documented through self-certification.

The HoH is eligible because they have experience (check one):

- Continuous homelessness on the streets or in shelters for one (1) year or longer (document **at least** the last year).
- Four (4) or more occasions of homelessness totaling 12+ months on the street or in shelters in the past three (3) years.

	Start Date	End Date	Duration	Location (Type)	Locations (Provider name of location description)	Documentation	Attached
Episode 1				<input type="checkbox"/> Place not meant for habitation. <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Institution <90 days		<input type="checkbox"/> HMIS or Institutional record <input type="checkbox"/> Housing/Service Provider <input type="checkbox"/> Outreach/Referral Provider <input type="checkbox"/> Client Self-Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Episode 2				<input type="checkbox"/> Place not meant for habitation. <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Institution <90 days		<input type="checkbox"/> HMIS or Institutional record <input type="checkbox"/> Housing/Service Provider <input type="checkbox"/> Outreach/Referral Provider <input type="checkbox"/> Client Self-Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Episode 3				<input type="checkbox"/> Place not meant for habitation. <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Institution <90 days		<input type="checkbox"/> HMIS or Institutional record <input type="checkbox"/> Housing/Service Provider <input type="checkbox"/> Outreach/Referral Provider <input type="checkbox"/> Client Self-Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Episode 4				<input type="checkbox"/> Place not meant for habitation. <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Institution <90 days		<input type="checkbox"/> HMIS or Institutional record <input type="checkbox"/> Housing/Service Provider <input type="checkbox"/> Outreach/Referral Provider <input type="checkbox"/> Client Self-Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No

Certifications

I, the Head of Household named below, certify that the timelines documented above is accurate to the best of my knowledge.

Head of Household Name (Printed): _____ Signature: _____ Date: _____

I, the Staff named below, certify that the timeline documented above is accurate as the HoH described it during the interview(s) conducted on the following date(s): _____

Staff Name (Printed): _____ Signature: _____ Date: _____