Missouri Department of Mental Health
Shelter Plus Care Program
Eligibility Packet

GENERAL INFORMATION

- For help with this form, contact the DMH Housing Unit at housing@dmh.mo.gov or at **573-526-3125**.
- For eligibility processing and referral information, call **573-751-9206**.
- 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.
- ***Know what the head of household's housing status is.*** Only persons who are homeless per HUD's definition are eligible for Shelter Plus Care assistance. This means persons who are currently sleeping in places not meant for human habitation or in emergency shelters, or who are currently living in Safe Havens, institutions, or transitional housing programs. If your client has not been in one of these settings within the past 30 days, he or she is not eligible for Shelter Plus Care assistance.
- ***Include documentation*** of the household's homelessness. ***This is required.*** No household can be found eligible for assistance without documentation of homelessness. See the Instructions on the next page for more information on what constitutes eligible homelessness and how to document it.
- ***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 fill out and fax us pages we don't need.*** Don't fax us these instructions or the Eligibility Packet Checklist.

Missouri Department of Mental Health
Shelter Plus Care Program
Eligibility Packet Instructions

HOW TO DOCUMENT EPISODES OF HOMELESSNESS

In Attachment B, "Verification of Homelessness," choose one of three situations that describe the Head of Household's current homelessness situation, and then describe in detail any prior episodes of homelessness for the past three years. Include documentation of each episode of homelessness described on Attachment B. Listed below are the situations that qualify a Head of Household as homeless, and how to document them.

1. **'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.

   How to document it: The above situation should be personally observed and verified, and described in a letter. Normally this is written by the Head of Household's referring agency contact person, but a third party may also be able to verify homelessness, such as an outreach worker, law enforcement, or other person who has witnessed the situation. In the letter, include specific locations, dates, and describe in what way the situation constitutes a place not meant for human habitation. The letter must be on agency letterhead, and must be signed and dated by the author. In cases where the street homelessness occurred in the past, it can be self-reported by the household, and then detailed in the letter.

2. **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.

   Note: "Safe Haven" refers to certain HUD-funded apartment-based programs for chronically homeless disabled individuals; persons living in Safe Havens are considered homeless. There are two Safe Havens in Missouri: The Haven in St. Joseph, and the Safe Haven in Dunklin County.

   How to document it: For shelters and Safe Havens, obtain a letter from the facility verifying the date(s) of entry and exit and that the Head of Household currently resides there, if applicable; **or** a printout from the Compass Rose or MAACLink HMIS systems showing recorded shelter stays.

   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 (same documentation as detailed above).

   For an emergency stay in a **hotel or motel**, obtain a letter from the agency that paid for the stay, stating the dates paid for and the reason, and a copy of the hotel/motel receipt.

3. **Institutional stays**: 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.

   How to document it: Obtain a signed and dated letter from the institution verifying that the Head of Household has lived there for ninety days or less and is about to exit the institution; **and** documentation that the Head of Household's housing immediately prior to the institution was either an emergency shelter, Safe Haven, or a place not meant for human habitation (same documentation as described in 1 and 2, above).

Missouri Department of Mental Health
Shelter Plus Care Program
Eligibility Packet Checklist

➲ *The purpose of this checklist is to help you complete a Shelter Plus Care Eligibility Packet. Please do not send this page with the Eligibility Packet.*

☐ Sections 1-7 of the form are filled out completely. Skip Section 3 if there are no other adults in the household; skip Section 4 if there are no minors in the household.

☐ The Head of Household has signed the Head of Household Certifications (Section 6).

☐ The referring agency contact person has signed the Referring Agency Certifications (Section 7).

☐ Attachment A (Disability Verification) is completely filled out with one option checked; is signed by a person with the proper credentials; and the signer has listed his or her license number.

☐ Attachment B (Homelessness Verification) is completely filled out with ONE option checked and all episodes of homelessness for the past three years have been described in detail.

☐ All episodes of homelessness for the past three years have been documented (*see* Instructions for required documentation).

☐ Attachment C—Consent for Disclosure of Head of Household's Protected Health Information is completely filled out and signed by the Head of Household and a witness.

☐ The Head of Household has, or is working on obtaining, all required forms of identification and proof of income, if any, for all members of the proposed household.

☐ The HMIS Data Form is:

(For St. Louis City and County, Jackson County, and St. Joseph households)

☐ Ready to be completed and taken to the Household's briefing meeting after DMH refers the Household to a processing center agency.

OR

(For households in all other parts of Missouri)

☐ Completed and will be submitted to DMH with this Eligibility Packet.

(If you don't know what the HMIS Data Form is, visit http://dmh.mo.gov/housing/housingunit/shelterpluscare.html for more information.)

Shelter Plus Care Eligibility Packet

DMH Housing Unit | 1706 E. Elm Street | Jefferson City MO 65101
573-751-9206 | FAX 573-526-7797 | housing@dmh.mo.gov | http://dmh.mo.gov/housing/

➢SECTION 1. HEAD OF HOUSEHOLD INFORMATION

First Name: ______________________ **Middle** ___________________________ **Last Name:** ______________________________

Social Security Number: _________ - _________ - _________ **Date of Birth:** _________ / _________ / _________

➢SECTION 2. REFERRING AGENCY CONTACT INFORMATION

Name: ____

Agency: ____ **City:** ____

Office Phone: (_______) ___________________________________ **Fax: (_______)** __________________________________

Email Address: ____ @ ____

➢SECTION 3. OTHER ADULTS IN THE HOUSEHOLD (Age 18+)

Use an additional copy of this page if the household has more than one other adult aside from the Head of Household.

First Name: ______________________ **Middle** ___________________________ **Last Name:** ______________________________

Date of Birth: ____

➢SECTION 4. MINORS IN THE HOUSEHOLD (Age 17 and <)

Use additional copies of this page if the household has more than three minors.

First Name: ______________________ **Middle** ___________________________ **Last Name:** ______________________________

Does the Head of Household have legal custody of this minor? ☐ **Yes** ☐ **No**
If "yes," please specify: ☐ full custody ☐ joint custody (minor lives with or will live with the HOH at least 50% of the time)

Date of Birth: ____

First Name: ______________________ **Middle** ___________________________ **Last Name:** ______________________________

Does the Head of Household have legal custody of this minor? ☐ **Yes** ☐ **No**
If "yes," please specify: ☐ full custody ☐ joint custody (minor lives with or will live with the HOH at least 50% of the time)

Date of Birth: ____

First Name: ______________________ **Middle** ___________________________ **Last Name:** ______________________________

Does the Head of Household have legal custody of this minor? ☐ **Yes** ☐ **No**
If "yes," please specify: ☐ full custody ☐ joint custody (minor lives with or will live with the HOH at least 50% of the time)

Date of Birth: ____

DMH Housing Use Only

Jackson County ☐	St. Louis City ☐	Bootheel ☐	Hannibal ☐	Outer KC Metro ☐	West Plains ☐
Joplin ☐	St. Louis County ☐	Branson ☐	Jefferson-Franklin ☐	Poplar Bluff ☐	
Springfield ☐		Central Missouri ☐	Kirksville ☐	Rolla ☐	
St. Joseph ☐		Farmington ☐	Nevada ☐	West Central ☐	

Forms:	Applicant ☐	Other Adults ☐	Minors ☐	Disability ☐	Homeless ☐	Consent ☐
Eligibility:	Disabled ☐	Homeless ☐	Income ☐			
Disability:	SMI ☐	CSA ☐	SMI/CSA ☐	PWA ☐	PWOD ☐	
Chronic:	Yes ☐	No ☐				

➢SECTION 5. INCOME

Head of Household: have you, or anyone who will live with, you received income from any source in the past 30 days?
☐ Yes ☐ No **If "yes," please specify below:**

- Source of income (do not include non-cash sources such as food stamps and WIC): _____

  _____

  _____

- Total amount received per month: $_____

➢SECTION 6. 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*)

➢SECTION 7. 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*)

➢_____ ➢_____
(*Signature of Referring Agency Contact Person*) **(*Name of Referring Agency*)**

➢_____
(*Date*)

➢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)

➢ATTACHMENT B. VERIFICATION OF HOMELESSNESS

Head of Household Name: _____

- **FIRST**: Check one item from the list below that describes the Head of Household's current homelessness situation. You must include documentation of the Head of Household's homelessness (refer to the Instructions at the beginning of the Eligibility Packet for how to document homelessness). No Head of Household can be found eligible for assistance without required documentation of homelessness.

The Head of Household is homeless as defined by HUD because he or she is currently:

☐ An individual or family with 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, including a car, park, abandoned building, bus or train station, airport, or camping ground

☐ An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including 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).

☐ An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

- **SECOND**: Use the space below to detail the Head of Household's housing and homelessness history for the past three (3) years. Please be as detailed as possible as to dates and locations. Describe all episodes of homelessness that fit any of the three categories listed above. Alternatively, you may also provide this information in a signed and dated letter (must be on your agency letterhead) and include it in the Eligibility Packet following this form. You must also include documentation of the Head of Household's homelessness history (refer to the Instructions at the beginning of the Eligibility Packet for how to document homelessness).

Time Period	**Location (e.g., name of shelter or institution, physical location if 'street' homeless, etc.)**
Examples:	
Oct. 1, 2015 – Nov. 30, 2015	Client slept in her car, which was usually parked at or near 10th St. & Main in Grandeville, MO
July 1, 2015 – July 31, 2015	Client resided at Woods Avenue Shelter in Smalltown, MO

➢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: _____

_____