Description and Eligibility

Home Stretch is a project of the Alameda County Health Care Services Agency in collaboration with EveryOne Home and partnering agencies to help *literally homeless individuals with disabilities,* and their families, link with appropriate resources, services, and permanent housing as quickly as possible. Eligible individuals and households referred to Home Stretch are prioritized for access to services and permanent supportive housing resources in Alameda County based on their level of need and the length of time they have experienced homelessness. Home Stretch functions as a referral list for most permanent supportive housing programs in Alameda County. It does not operate as a waiting list for all affordable housing opportunities, so individuals and households referred to Home Stretch should get on waiting lists as they become open.

To be eligible, people must meet the following criteria at the time of referral:

- The individual (or head of household) is living on the streets, in abandoned buildings, parks, a vehicle, or other outside place not meant for people to live, in an emergency shelter or emergency housing program, or a transitional housing program for homeless individuals OR is in an institutional care facility for fewer than 90 days and was in one of the previously listed living situations prior to entering the institution; AND

- The individual (or head of household) has a disabling health condition(s), such as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, that is expected to be of long-continued and indefinite duration and substantially impedes the persons' ability to live independently.

Individuals that meet one or both of the criteria ***below*** receive prioritized access to resources. Highest priority is given to individuals that meet both of the following criteria:

- The individual (or head of household) has been staying in a place not meant for human habitation or a shelter for more than one year continuously or four or more times over the past three years with more than 12 months of cumulative time living on the streets or in shelters; AND

- The individual (or head of household) has high priority needs as demonstrated by *at least* one of the following (*see Home Stretch High Services Need Verification Form for details*):
    - Frequent verified contact with health or law enforcement agencies over the last 12 months
    - High health risks with verified medical diagnoses
    - A VI-SPDAT screening score of 8 or more

NOTE: A head of household for a family that meets the above criteria makes the family eligible for Home Stretch.

If the individual **is eligible**, please complete a Home Stretch Referral Packet that includes all of the following:

- ☐ Completed Fax Cover Sheet
- ☐ Completed and Signed Home Stretch Consent to Release of Information (ROI)
- ☐ Completed InHOUSE Standard Intake Form
- ☐ Home Stretch High Service Need Verification Form and Supporting Documents (if applicable)
- ☐ Home Stretch Contact Information Form

Guide to HUD "Chronic Homelessness" Definition

Individuals that meet the federal Housing and Urban Development Department (HUD) definition of chronic homelessness receive prioritized access to certain services and housing opportunities linked with Home Stretch. According to HUD, chronic homelessness means*:

(1) A homeless individual or head of household with a disability that meets the HUD definition of a disability who
   (a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND
   (b) has been homeless and living in one of these places continuously for at least 12 months OR on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living in one of the aforementioned places.

Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility. Institutional care facilities include jails, substance abuse or mental health treatment facilities, hospitals, or other similar facilities.

A family with an adult head of household (or if there is not adult in the family, a minor head of household) who meets all of the above criteria, including a family whose composition has fluctuated while the head of household has been homeless are also considered chronically homeless.

Documentation of chronic homelessness requires:

1) Documentation of a client's housing history from one or more parties via third party verification, Homeless Management Information System (HMIS) records, or a client self-certification of homelessness with documentation of attempts to obtain this information that failed. *NOTE: Third-party documentation of a single encounter with a homeless service provider on a single day within 1 month is sufficient to consider an individual as homeless and living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter for the entire calendar month unless there is evidence of a break.*

2) Documentation of a disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be of long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently OR written verification from the Social Security Administration OR the receipt of a disability check. *NOTE: For Home Stretch, documentation from a licensed professional is preferable as this documentation can help qualify individuals for disability specific services and housing opportunities that the other forms of documentation may not provide.*

**Please note: This is an updated definition of chronic homelessness issued by HUD effective 1-15-16.*

Home Stretch Document Flow Diagram

Outreach and Referral	Home Stretch Staff	Housing Navigation – helping people obtain permanent housing	Housing Match – Housing Locator and PSH Service Providers
Home Stretch Referral Documents: • Fax Cover Sheet and Checklist • Home Stretch/HMIS Release of Information Form • HMIS Standard **Intake** Form • Priority Assessment – VI-SPDAT 2.0 (Family, Single, or TAY) or verification of frequent contact with health/law enforcement or medical diagnostic verification • Contact Information Form	*Workflow:* 1. Referral review and feedback 2. Eligibility determined by HMIS Standard Intake 3. Eligible individuals entered into HMIS 4. Prioritization of Home Stretch clients and linkage with housing navigators based on priority and capacity	*Document Readiness- Required Forms:* • Housing Profile Form • Government- issued photo ID • Social Security Card • Vets verification (if applicable) • Disability verification (specific type, if applicable to client) – serious mental illness, HIV/AIDS, developmental disability, substance use disorder • Homelessness Verification *Document Readiness- Recommended Forms:* • Income Verification • Tenant Resume/Sample Housing Application • Tenant/Credit History Report • Other Documents from Household Members or Special Needs (see Home Stretch Documentation Checklist for further info)	*Home Stretch Staff:* • Match "document ready" clients to available housing based on criteria and prioritization. *Documents Required at Match:* • Income verification (<60 days) • Homelessness verification (<60 days) • Program Specific Applications and Forms *Housing Locator:* • Works with landlord to finalize move-in agreements *PSH Service Providers:* • Housing retention, health, increase assets, positive transitions

Consent for the Release of Confidential Health, HIV/AIDS, Alcohol or Drug, Mental Health, and Housing Information to Alameda County Health Care Services Agency – Home Stretch

Home Stretch is a collaborative project of the Alameda County Health Care Services Agency and the members of its health, HIV/AIDS, alcohol or drug, mental health, and the InHOUSE housing, services, and program network. A list of current programs participating in Home Stretch is available upon request and at the following website: http://everyonehome.org/our-work/home-stretch/

I, _____, authorize
(Print Name of participant/patient)

Home Stretch participating agencies to communicate with and disclose to one another the following information to help me obtain permanent housing and needed and desired services. *Information will only be shared with and used by people associated with the Home Stretch project that need and will use my information to help me obtain services and housing* [initial each category that applies]:

_____ **Data collected about me and entered into the InHOUSE (HMIS data) system** including intake, annual update, exit, program entry/exit, and services data. This data includes my name, age, date of birth, gender, race, ethnicity, marital status, veteran status, education, disability information, employment information, household relationships, living situation, income amount and type, benefits information, health insurance, income amount and type, benefits information, pregnancy status, legal information, programs and services needed and provided, and outcomes of services provided;

_____ Initial and subsequent evaluations of my service needs and health conditions by Home Stretch and its network members;

_____ Summaries of physical health, HIV/AIDS, alcohol/drug and mental health assessment results and service use history for the past 12 months.

_____ Other: _____

The purpose of the disclosures authorized in this consent is to: Enable Home Stretch and its network members to evaluate my need and desire for services, provide and coordinate services to me, determine my eligibility for specific service and housing programs, and to support me in obtaining permanent housing.

Consent for the Release of Confidential Health, HIV/AIDS, Alcohol or Drug, Mental Health, and Housing Information to Alameda County Health Care Services Agency – Home Stretch

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that records concerning mental health services I receive are protected by state law.

I understand that I may revoke or "take back" this consent at any time. If I "take back" my consent, however, this will only effect future sharing of information. Information shared prior to taking back my consent cannot be changed retroactively. This consent expires automatically 6 months after the date of my last services from a Home Stretch provider. Home Stretch services end after I obtain permanent housing. To revoke this consent, I must request in writing my wish to take back my consent with a designated Home Stretch provider OR with the Alameda County Health Care Services Agency – 1404 Franklin St., STE 200, Oakland CA 94612; homestretch@acgov.org OR by fax to (855) 658-5466. I have the right to receive a copy of all InHOUSE (HMIS) information collected about me and shared between participating agencies. I may also amend and correct InHOUSE (HMIS) information collected about me, which may be incorrect.

I understand the potential for information shared about me under this authorization to be redisclosed or shared again by the recipient and not necessarily protected by this authorization. I understand that the purpose of Home Stretch is the coordination of care and improved access to services and permanent housing resources. I understand that I will not be able to participate in coordinated care if I do not sign this Authorization, but individual service providers and government agencies listed may not deny me services if I refuse to sign this authorization. *I have been provided a copy of this form.*

_____ _____

Date Signature of Client

_____

Signature of person signing form if *not* client

Describe authority to sign on behalf of client: _____

Agency Representative that helped with this consent form:

_____

Print Agency Representative Name Agency Name

_____

Signature of Agency Representative

Home Stretch Referral Packet
Fax Cover Sheet

FAX

TO: EveryOne Home – Home Stretch	FROM:
FAX: (855) 658-5466	FAX:
PHONE: (510) 891-8938	PHONE:
SUBJECT: Referral to Home Stretch	DATE: [Click to select date]

Contact for Questions about Referral

Name: _____

Agency/Program: _____

Phone Number: _____

E-mail: _____

Are you the client's Houisng Navigator? ☐ Yes ☐ No

If not, please list Housing Navigator' s name and contact information (if known):

_____

Make sure you verify eligibility AND include all of the following with the referral (Complete Checklist):

Client HMIS ID# (if known):_____

- ☐ Completed and Signed Home Stretch Consent to Release of Information (ROI); AND
- ☐ Completed InHOUSE Standard Intake Form OR updated data in HMIS for this client; AND
- ☐ Home Stretch Contact Information Form OR updated contact information in HMIS for this client.
- ☐ Home Stretch High Service Need Verification Form and Supporting Documents OR updated VI-SPDAT in HMIS (if applicable)

Home Stretch – Participating Providers

• Abode Services • Affordable Housing Associates • Alameda Alliance for Health • Alameda County Housing and Community Development • Alameda County Health Care Services Agency Health Care for the Homeless and Behavioral Health Housing Services Office • Alameda Health System • Alameda Point Collaborative • Anka Behavioral Health, Inc. • Anthem Blue Cross – Alameda County Medi-Cal Plan and Provider Network • Ark of Refuge • Bay Area Community Services • Bay Area Legal Aid • Bay Area Youth Collaborative • Berkeley Drop-In Center • Berkeley Food and Housing Project	• Bonita House, Inc. • BOSS • Building Futures with Women and Children • City of Berkeley Department of Health, Housing, and Community Services • City of Oakland Department of Human Services • Community Health Center Network (CHCN) Federally Qualified Health Centers • Covenant House • Davis Street Family Resource Center • East Bay Community Law Center Eviction Prevention Housing Clinic • East Bay Community Recovery Project • East Oakland Community Project • Eden Information and Referral (2-1-1) • EveryOne Home • FESCO • First Place for Youth • Fred Finch Youth Center • Goodwill Industries, Inc.	• Homeless Action Center • Housing Consortium of the East Bay • LifeLong Medical Care • Operation Dignity • Options Recovery Services • Resources for Community Development • Roots Health Center • Rubicon Programs • Second Chance • St. Mary's Center • Satellite Affordable Housing Associates • Sutter Health East Bay – Alta Bates, Summit, and Eden Medical Centers • Swords to Plowshares • Tri-City Health Center • U.S. Department of Veteran Affairs • Volunteers of America • Women's Day Time Drop-In Center • Workforce Collaborative • YEAH!

InHOUSE Standard Intake Form v. 5.4 Effective 10/01/2015

Project Name: _____ **Start:** ☐☐/☐☐/☐☐ **ServicePoint ID:** ☐☐☐☐☐

Entry Type: ☐ HUD ☐ VA ☐ PATH

First: _____ **Middle:** _____

Last: _____ **Suffix:** _____

Alias: _____

Social Security Number: ☐☐☐☐☐☐☐☐☐

☐ Full name reported ☐ Partial, Street or Code Name

☐ Client doesn't know ☐ Client refused

Date of Birth: ☐☐/☐☐/☐☐

☐ Full DOB reported ☐ Approx or Partial DOB

☐ Client doesn't know ☐ Client refused

☐ Full SSN ☐ Approximate or Partial SSN

☐ Client doesn't know ☐ Client refused

Household Information

What kind of household do you have?

☐ Single adult, no children ☐ Female single parent ☐ Male single parent ☐ Couple with no children

☐ Two parent family with children ☐ Couple (parent and friend) and children ☐ Foster parent(s) and children ☐ Grandparent(s) and children

☐ Non-custodial caregiver(s) ☐ Other: _____

Relationship to Head of Household:

☐ Self (Head of Household) ☐ HoH's **child** ☐ HoH's **spouse** or **partner**

☐ HoH's other relation member ☐ Other: non-relation member

Race *(Select all that apply—up to five responses)*

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Client doesn't know ☐ Client refused

Residence Prior to Project Entry *(Where did you stay last night?)*

☐ **Emergency Shelter** (including hotel or motel paid for with an emergency shelter voucher) ☐ **Transitional Housing** for homeless persons (including homeless youth) ☐ **Place not meant for habitation** (e.g. vehicle, abandoned building, bus/train/subway station/airport or anywhere outside)

☐ Hotel or motel paid for without emergency shelter voucher ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy

☐ Rental by client, with GPD TIP (transition-in-place) subsidy ☐ Rental by client, with other ongoing subsidy ☐ Residential project or halfway house with no homeless criteria

☐ Hospital or other residential non-psychiatric medical facility ☐ Psychiatric hospital or other psychiatric facility ☐ Jail, prison or juvenile detention facility

☐ Staying or living in a FAMILY member's room, apartment or house ☐ Staying or living in a FRIEND'S room, apartment or house ☐ Substance abuse treatment facility or detox center

☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons (CoC project; HUD legacy programs; or HOPWA PH, or Rapid Re-housing)

☐ Long-term care facility or nursing home ☐ Safe Haven (note: none in Alameda Co.) ☐ Foster care home or foster care group home

☐ Client doesn't know ☐ Client refused ☐ Other: _____

Veteran Status

☐ No ☐ Yes

Gender

☐ Female
☐ Male
☐ Transgender male to female
☐ Transgender female to male
☐ Client doesn't know
☐ Client refused
☐ Other: _____

Ethnicity

☐ Non-Hispanic/Non-Latino
☐ Hispanic/Latino
☐ Client doesn't know
☐ Client refused

Last night's location

☐ Alameda
☐ Albany
☐ Berkeley
☐ Castro Valley
☐ Dublin
☐ Emeryville
☐ Fremont
☐ Hayward
☐ Livermore
☐ Newark
☐ Oakland
☐ Piedmont
☐ Pleasanton
☐ San Leandro
☐ San Lorenzo
☐ Sunol
☐ Union City
☐ Other unincorporated Alameda County
☐ Other California County
☐ Other State
☐ Other Country

Length of stay in Residence prior to entry

☐ One day or less ☐ Two days to one week ☐ More than one week, but less than a month ☐ One to three months

☐ More than three months, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused

Standard Intake

InHOUSE Standard Intake Form

Length of Time on Street, or in Emergency Shelter

Client entering from the streets, shelter or safe haven?	☐ No ☐ Client doesn't know	☐ Yes ☐ Client doesn't know
→ If **Yes,** Approximate date started:	__ __ / __ __ / __ __	
Number of **times** homeless (on the streets or in an emergency shelter, or safe haven) in the past three years including today:	☐ Never in the 3 years ☐ One time ☐ Two times ☐ Three times	☐ Four or more times ☐ Client doesn't know ☐ Client refused
Total number of **months** homeless on the street, in emergency shelter, or safe haven in the past three years:	☐ One month (this time is the first month) ☐ 2-12 months (___ months) ☐ More than 12 months	☐ Client doesn't know ☐ Client refused

Domestic Violence

Are you, or have you been a survivor of domestic or intimate partner violence?

☐ No	☐ Yes
☐ Client doesn't know	☐ Client refused

→ **If YES, how long ago did you have this experience?**

☐ Within the past 3 months	☐ One year ago or more
☐ 3 to 6 months ago	☐ 6 months to 1 year ago
☐ Client doesn't know	☐ Client refused

→ **If Yes , are you currently fleeing ?**

☐ No	☐ Yes
☐ Client doesn't know	☐ Client refused

Housing Status

Homeless and At-Risk of Homelessness Status

☐ **Category 1 -** Homeless	☐ **Category 4** — Fleeing domestic violence
☐ **Category 2** - At imminent risk of losing housing	☐ At-risk of homelessness
☐ Category 3 - Homeless only under other federal statutes	☐ Stably housed

CoC Location

☒ CA-502

In permanent housing

☐ No
☐ **Yes** (complete **Housing Assessment** form)

Move-in date:

__ __ / __ __ / __ __

Education

What is the highest level of school that you have completed?

☐ Less than Grade 5	☐ Grades 5-6	☐ Grades 7-8	☐ Grades 9-11
☐ Grade 12	☐ School program does not have grade levels	☐ GED	☐ Some college
☐ Client doesn't know	☐ Client refused		

Employment

Are you presently employed?

☐ No	☐ Yes	☐ Client doesn't know	☐ Client refused

If employed, is this permanent, temporary or seasonal work?

☐ Full-time	☐ Part-time	☐ Seasonal	☐ Client doesn't know

City/State Info

Answer the questions below, using the values at right:

What is the City, State of your last permanent housing where you lived for 90 days or more?

_____

What is the City, State of the high school you last attended? (child: blank)

_____

What is the City, State of your family residence when you were born?

_____

Alameda County:		Other County:
1 Alameda	**10** Newark	**19** Contra Costa
2 Albany	**11** Oakland	**20** Marin
3 Berkeley	**12** Piedmont	**21** San Francisco
4 Castro Valley	**13** Pleasanton	**22** San Mateo
5 Dublin	**14** San Leandro	**23** Santa Clara
6 Emeryville	**15** San Lorenzo	**24** Other California County
7 Fremont	**16** Sunol	**25** Other State
8 Hayward	**17** Union City	**26** Other Country
9 Livermore	**18** Other unincorporated Alameda County	

Standard Intake

InHOUSE Standard Intake Form v. 5.4

Income

☐ No/None at all ☐ **Yes** (Identify source and amounts)
☐ Client doesn't know ☐ Client refused

Source:	Amount:
☐ Earned income **(i.e., employment income)**	$ __ __ __ __ . 00
☐ Unemployment Insurance	$ __ __ __ __ . 00
☐ Supplemental Security Income **(SSI)**	$ __ __ __ __ . 00
☐ Social Security Disability Income **(SSDI)**	$ __ __ __ __ . 00
☐ Retirement Income from Social Security	$ __ __ __ __ . 00
☐ VA Service-Connected Disability Compensation	$ __ __ __ __ . 00
☐ VA Non-Service-Connected Disability Pension	$ __ __ __ __ . 00
☐ Worker's Compensation	$ __ __ __ __ . 00
☐ Temporary Assistance for Needy Families **(TANF)**	$ __ __ __ __ . 00
☐ General Assistance **(GA)**	$ __ __ __ __ . 00
☐ Private disability Insurance	$ __ __ __ __ . 00
☐ Pension or retirement income from a former job	$ __ __ __ __ . 00
☐ Child Support	$ __ __ __ __ . 00
☐ Alimony or other spousal support	$ __ __ __ __ . 00
☐ Other source: _____	$ __ __ __ __ . 00
Total Monthly Income:	**$ __ __ __ __ . 00**

Non-Cash Benefits

☐ No/None at all ☐ **Yes** (Identify source below)
☐ Client doesn't know ☐ Client refused

Source:

☐ Supplemental Nutrition Assistance Program **(SNAP/CalFresh)**
☐ Special Supplemental, Nutrition Program for Women, Infants, and Children **(WIC)**
☐ **TANF Child Care services**
☐ **TANF transportation services**
☐ **Other TANF-funded services**
☐ **Section 8, public housing, or other ongoing rental assistance**
☐ **Temporary rental assistance**
☐ **Other:** _____

Health Insurance

Covered by Health Insurance:

☐ No ☐ **Yes** (Identify source below)
☐ Client doesn't know ☐ Client refused

Source:

☐ MEDICAID/MediCal ☐ MEDICARE
☐ State Children's Health Insurance Program **(SCHIP)** ☐ Veteran's Administration **(VA)** Medical Services
☐ Employer-Provided Health Insurance ☐ Health Insurance obtained through COBRA
☐ Private Pay Health Insurance ☐ State Health Insurance for Adults

Disability

Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a developmental disability, HIV/AIDS, or a diagnosable substance abuse problem?

☐ No ☐ **Yes** (Indicate type(s) below) ☐ Client doesn't know ☐ Client refused

	☐ **Physical**	☐ **Mental Health**	☐ **Chronic Health Condition**	☐ **Alcohol** ☐ **Drugs** ☐ **Both**	☐ **Developmental**	☐ **HIV/AIDS**
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	☐ Yes	☐ Yes	☐ Yes	☐ Yes	N/A	N/A
Expected to substantially impair ability to live independently:	N/A	N/A	N/A	N/A	☐ Yes	☐ Yes
Documentation of the disability and severity on file:	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Currently receiving services/treatment for this disability:	☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused

Staff Completing (Printed Name):	**Date:**

Standard Intake

Contact Information

Client Name: _____ Client HMIS ID# (if known): _____

Client Phone Number (if available): _____

Client Mailing Address (if available): _____

Client Email Address (if available): _____

Alternative Contact Name #1: _____

Alternative Contact #1 Phone Number (if available): _____

Alternative Contact #1 Email Address (if available): _____

Alternative Contact #1 Relationship to Client Description (please note if this person will be acting as the client's Housing Navigator):

Alternative Contact Name #2: _____

Alternative Contact #2 Phone Number (if available): _____

Alternative Contact #2 Email Address (if available): _____

Alternative Contact #2 Relationship to Client Description
