

**DEPARTMENT OF HUMAN ASSISTANCE  
HOMELESS PROGRAM**

**DOCUMENTATION OF CHRONIC HOMELESSNESS**

Name: \_\_\_\_\_

The above named person is an unaccompanied individual and has:

**Part I:**

Been homeless for a year or more, or

Had four episodes of homelessness in the past three years

**Note: To be considered chronically homeless a person must have been on the streets or in an emergency shelter (i.e. not transitional housing).**

Please note and attach any documentation or information available that supports the box checked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part II:**

The above named person has a documented disabling condition, which is:

Serious mental illness

A diagnosable substance abuse disorder

A developmental disability

A chronic physical illness or disability

**Note: A County of Sacramento SHP Disability Certification will need to be completed.**

\_\_\_\_\_  
Signature of staff completing form

Date: \_\_\_\_\_