

VERIFICATION OF THIRD PARTY HOMELESSNESS

Agency Name: _____

Date: _____

Agency Address: _____

Regarding Client: _____

I, _____, _____, from _____,
(Full Name) (Title, e.g. fire, police, case manager, other) (Agency Name)

verify that _____ has been homeless from ____/____/____
(Client Name) (Start Date)

to ____/____/____. During this time, our agency interacted with _____.
(End Date, or today's date if still experiencing homelessness) (Client Name)

I witnessed the client residing in the following living situation:

- In Emergency Shelter
- On the Streets/Place not Meant for Human Habitation
- An Institutional Care Facility for fewer than 90 days, e.g. Jail, Hospital, Rehab, etc.*

*Institutional care means care provided in a hospital, nursing home, or other facility certified or licensed by the state primarily affording diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services.

Other (please specify)

Our agency provided the following services (if services were administered):

Should you have any questions, you may contact me via phone at _____, and
via email _____.

Sincerely,

Signature of Agency Representative