

**Third-Party Attestation Form for
Homelessness**

I attest that _____
(Name of Applicant)

Medicaid #: _____; SS#: _____; DOB: _____

lacks a fixed, regular, and adequate nighttime residence and is homeless:

1. they have a primary nighttime residence that is:
_____ a public or private place not meant for human habitation.

2. they live in
_____ a publicly or privately operated shelter designated to provide temporary living arrangements.

Name of Shelter _____; Type: _____

Address of Shelter _____
_____ (Specify place)

3. they are exiting an institution:
_____ where they have resided for 90-days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering the institution.

Name of Institution _____

Address of Institution _____

Specific information about your relationship to the applicant and an explanation of how you are in a knowledgeable position to attest to the fact(s) cited above, including dates of encounters (Note: Use the back of this form if additional space is needed):

(Print Name of Attesting Individual)

(Title of Attesting Individual)

(Agency of Attesting Individual)

(Contact Telephone #)

(E-mail address)

(Signature of Attesting Individual)

(Date)



Office Use Only: Eligible; Not Eligible, Explain _____

H.O.M.E. Program Date _____ Staff _____ Title _____