

PHILADELPHIA CONTINUUM OF CARE
THIRD PARTY VERIFICATION OF INSTITUTIONAL STAYS

This form should be used to document the Applicant's stays in **Institutional Care Facilities ONLY**. This form is only necessary if:

- The institutional stay was less than 90 days (89 days or less) **AND**
- The institutional stay was within the previous 3 years **AND**
- The applicant had been staying in a place not meant for human habitation, safe haven, or emergency shelter immediately prior to entering the institution.

Institutional Care Facilities include, but are not limited to: Hospital, Jail/Prison, Nursing Home, Psychiatric Facility

Staff from Institutional Care Facilities: Please complete **Sections I and II**.

Staff from Housing Program: If unable to receive written verification from the institutional care facility, program staff may receive oral verification of the institutional stay. To do so, please complete **Sections I, II, and III**.

Applicant Name:	Date of Birth: / /	Last 4 SSN Digits:
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Section I. Institution Information

Name of Institution:

Type of Institutional Setting:

<input type="checkbox"/> Psychiatric facility	<input type="checkbox"/> Jail, prison, or juvenile detention
<input type="checkbox"/> Substance abuse or detox center	<input type="checkbox"/> Foster care home or foster care group home
<input type="checkbox"/> Hospital (non-psychiatric)	<input type="checkbox"/> Other (describe): _____

Documentation of Stay(s)
 The above named individual stayed at the institution named in Section A during the following time period(s) within the last 3 years (start with the most recent period, if there is more than one occasion):
**If the applicant stayed at more than one facility/program, a separate form must be completed by each program/facility.*

Entry Date (MM/DD/YY): / /	Exit Date (MM/DD/YY): / / or <input type="checkbox"/> Currently staying at facility/program
/ /	/ /
/ /	/ /

Any other relevant information:

Section II. Verification by Representative of the Institutional Care Facility

The information in Section I was provided by:

Name:	Verification Date: / /
Title:	Agency:
Phone Number:	Email:

Verification was provided: Over the phone In Person
 Institutional Care Facility Representative Completed this Form

Signature of Institutional Care Facility Representative
 (if s/he is the one completing this form):

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Section III. Program Staff Certification

If the information in Section I was provided orally (over the phone or in person), program staff must complete this section.

Staff Certification

I certify that I received oral verification of the applicant's stay in an Institutional Care Facility by the identified Representative of the Institutional Care Facility.

Printed Name:

Date: / /

Title:

Signature:

Agency:

Email: