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:**
John Doe	10/10/1950	2222

Section I. Institution Information

Name of Institution:
Philadelphia Hospital

Type of Institutional Setting:

- ☐ Psychiatric facility
- ☐ Substance abuse or detox center
- ☒ Hospital (non-psychiatric)
- ☐ Jail, prison, or juvenile detention
- ☐ Foster care home or foster care group home
- ☐ 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):
11/13/2015	12/03/2015 or ☐ 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: Shirley Smith	Verification Date: 10/12/2016
Title: Social Worker	Agency: Philadelphia Hospital
Phone Number: 215-111-1111	Email: ssmith@hospital.org

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):

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: Jane Michaels	Date: 10/12/2016
Title: Case Manager Supervisor	Signature:
Agency: Housing First	Email: jmichaels@housing.org